NATIONAL AND REGIONAL HEALTH PLANNING IN SWEDEN

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by

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PREFACE

When the Fogarty International Center was established in July 1968, it was immediately recognized that man must develop a more profound knowledge of medicine and public health in other cultural settings if he is to understand better his own situation. With this premise in mind, personnel of the Center initiated a series of studies of medicine and health in selected countries in order to determine the influence of other forms of governments upon the health system involved.

The first country to be studied was the U.S.S.R., inasmuch as it had originally served as a model for other communist governments of the world. A series of publications on the Soviet health system has resulted from these studies. The second major health system being examined is that of the People's Republic of China. Originally influenced significantly by the Soviet system, the Chinese Government modified the overall structure to meet its own cultural interests. The third type of system now being studied, as reflected in this publication, is that of the government of Sweden.

The form of government under which the Swedish health system operates is more easily understood in the United States because of the greater proximity of the two countries to each other and the closer communication between its peoples. The Foreword of this publication by Dr. Harold Margulies, Deputy Administrator, Health Resources Administration, Department of Health, Education and Welfare, explains clearly the need for a better knowledge of the health situation in Sweden.

The author, Dr. Vicente Navarro, Associate Professor, Department of Medical Care and Hospitals, The Johns Hopkins University, Baltimore, Maryland, is particularly well qualified to present this account of the Swedish health planning system. He has been a student of public health in Sweden and other Scandinavian countries for over one decade, having lived in Sweden in 1963 and since then visited that country on many occasions. Also, he has studied health systems in other countries, enabling him to place his knowledge of the Swedish system in greater perspective. His training and experience have been well

recognized by his appointment to numerous committees on health services, including groups associated with the World Health Organization and the Pan American Health Organization.

We should also like to emphasize that the comments contained in this publication in no way reflect the opinions of the Fogarty International Center, the National Institutes of Health, the Department of Health, Education and Welfare, or any other agency of the Federal Government.

Inquiries concerning this publication should be addressed either to the author or to Dr. Joseph R. Quinn, Head, Geographic Health Studies, Fogarty International Center.

Milo D. Leavitt, Jr., M. D.
Director
Fogarty International Center

FOREWORD

The United States has only recently begun to plan seriously for better health services throughout the nation. Initial efforts in the 1960's consisted of relatively isolated regional, State and local activities inserted into a wide assortment of traditional, categorical programs with the expectation that something more rational would emerge. No fundamental changes in the patterns of private medical practice were then envisaged, but voluntary cooperation was anticipated by sponsors and administrators of new legislation.

Those who assumed the burdens of health planning were frustrated by problems which have persisted: vague concepts of planning as a discipline; limited authority for implementation; public apathy and professional hostility toward official planning agencies; a dearth of meaningful data on health or related subjects; fiscal insecurity. Despite these handicaps there have been some gains. Regionalization of services had not been achieved but the need for better allocation of resources has been more fully accepted. The advantages of planning by health care institutions has been recognized and in many States has led to new statutes which guard against wasteful practices. The primary stimulus to date for health planning has been the Federal Government which, despite the uncertain progress, remains committed to the concept. It appears certain that this commitment will persevere and will lead to extensive improvements in the entire process.

Redesign of health delivery systems, which began in other countries much earlier, has been attracting increasing interest in the United States. What we once regarded with suspicion we now wish to understand better, even when the system established is one we might not wish to adopt.

Sweden has long been regarded by many as a model for social planning on a national scale. In the medical field this has included regionalization of medical services with apparent benefits to a progressively healthier population. Now that planning is accepted as an asset in the United States while efforts to regionalize have been gen-

erally ineffective, it is appropriate that we examine in detail the Swedish experience. Thus this important monograph.

Comparisons between different societies are hazardous but may be immensely useful. It has been easy for the opponents of change to insist that Sweden and the United States have no elements of comparability, that we can conclude little or nothing from a small country with a homogeneous population, free of extremes of wealth or poverty, united by generations of political stability, a common religion and geographic isolation. However valid these demurrers may be there are deeper considerations which affect similarly all attempts to improve systems of medical care. These include: a uniform method of payment for services; reconciliation of differences between central and local responsibilities, creation of a productive coordination of government and professional activities; appropriate involvement of the public in various aspects of the development and management of the system.

Dr. Navarro has wisely included in the monograph a thorough description of the elements of Swedish government. Only with this analysis can one appreciate the dynamics of planning which has the continuity and strength needed to produce the changes desired. Of particular interest are the relationships between administrators and Parliament, the role of civil servants, the move away from categorical to functional organization, and the high level of local responsibility in government. Decentralization in Sweden has direct meaning as planning in the United States is moving in the same direction.

The major segments of the monograph—national health insurance, the organization of health services, the use of data, and the process of planning, the details of regionalization—suggest for the United States some solutions of immediate interest. More important, the problems we must address and the pitfalls to be avoided are carefully delineated.

For students of public affairs the monograph is intriguing, for health professionals and planners it is an invaluable document.

Harold Margulies, M.D.
Deputy Administrator
Health Resources Administration
Department of Health, Education, and Welfare

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This monograph could not have been written without the generous cooperation of many Swedish planners, civil servants, politicians, academicians, trade unionists, businessmen, physicians, patients, and very many others, too numerous to mention all of them by name.

However, among this large group of people, special thanks are due to Dr. Ake Lindgren, head of the Department of Planning of the National Board of Health, without whose kind and invaluable assistance this project would not even have been started; Dr. Bror Rexed, Director General of the National Board of Health; Dr. Arthur Engel, its past Director General who, besides assisting me in understanding the subtleties of Swedish politics, was an excellent host; and Dr. Gunnar Inghe, Professor of Social Medicine at the Karolinska Institute.

Also, I was much helped by Dr. Gunnar Wennström, Head of the Manpower Division of the Department of National Planning of the National Board of Health, Dr. Christer Hogstedt, of the Department of Social Medicine of the Karolinska Institute, Dr. Laila Linnergren, planner of the National Federation of County Councils, and Dr. Edgar Borgenhammar, administrative director of the Stockholm Southern District, who all commented extensively on an earlier version of the manuscript. Their review was most helpful. The comments and critique of Professor Brian Abel-Smith of the London School of Economics and of Professors Kerr L. White and Philip D. Bonnet of The Johns Hopkins University are much appreciated.

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No acknowledgment would be complete without mentioning Renate Wilson and Leda Stevens, who edited and prepared the manuscripts. Thanks also to Dolores Kester for her help with the index. Last,

but certainly not least, thanks are also due to Anneli Höllta Ljungstrand, my spouse and partner, a Swedish citizen, whose assistance in strengthening my rusty Swedish and in helping me to understand Sweden more fully has been invaluable.

To all of those mentioned I want to express my gratitude, while reassuring them that I am solely responsible for the views expressed in this work.

VICENTE NAVARRO

Fall 1972

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INTRODUCTION

Sweden, a country approximately the width and length of California, and in a similar geographical location as Alaska, has a population of just over eight million people and has been governed for over 30 years by a Social Democratic Government. The wealthiest country in Europe by most economic and social indicators, Sweden has often been presented as the model of the modern welfare state. Other countries at similar levels of development have looked closely at Sweden's experience to see how Swedes have "solved" those problems that also beset them. One product of this intensive observation is an extensive and increasing literature on Sweden, dissecting different components of Swedish life, some with admiration, others with criticism. And from some of this abundant literature has come a great mythology, with Sweden presented as a "welfare heaven" by some progressives and as a "hotbed of sin, sex, and suicide" by some conservatives. To this observer, Sweden is neither. Actually, the social services in Sweden, with the exception of the health sector, are more similar than dissimilar to those in the United States in benefits and coverage. And of the three "ills," sin, sex, and suicide, the Swedish suicide rate, the only one that we can reasonably quantify, is not in excess of the average observed among European countries. In spite of this, the popular press persists in either glamorizing or, as the case may be, condemning a damaging mystique, a mystique to which sometimes the Swedes themselves are not immune.

This monograph was written to correct at least some aspects of this mystique. It represents not a superficial account that may tantalize the reader, but a detailed description of the Swedish experience, the summary of over ten years acquaintance with the Swedish health services. Aimed at students and practitioners of socioeconomic planning in general, and of health services planning in particular, it details the structures, processes and methods of national and regional health planning in Sweden, with comparative notes on health plan-

ning in the United Kingdom and, specifically, the experience of the United States.

Although the major emphasis is on national and regional health planning, this monograph is not limited to these aspects; for health planning does not occur in a vacuum but within the political structure of the country, the structure of its health services, and the process of its socioeconomic development. Both national and regional health planning is heavily dependent on, related to, and the result of these three and the sequence of this book reflects this dependence. The first chapter deals with the political structure of Sweden at the national, regional and local levels as the framework within which national and regional social (including health) and economic planning takes place. The values of this political system explain, but are not the only cause of the singular structure, organization, administration, and funding of Swedish health services, which are the subject of Chapter 2.

Health services in any country consume a considerable amount of energy and an increasing share of national resources. Indeed, in 1971, 7.2, 6.2, and 5.6 per cent, respectively, of the gross national product of the United States, Sweden, and the United Kingdom were spent in the health sector. Thus, an analysis of health services and of their national and regional planning cannot be attempted in isolation from the rest of the economy, but should take place against the background of the overall economy and its national and regional planning. These aspects and the study of their relation to the health services and their planning in Sweden are explained in Chapter 3. Furthermore, without an analysis and appraisal of the statics (structure) and dynamics (process) of the social and economic system and its components, the understanding of national and regional planning in urban and rural settings, which are discussed both in Chapters 4 and 5, would be limited.

In this monograph on Sweden and its health services planning, I have made a number of comparative notes on the British and American experience. An internationalist by choice and force of circumstance, having lived, studied, and worked in these three countries, it is both tempting and rewarding to me to compare the experiences of these three countries. A fair question, of course, is how much the Swedish practice, with its strengths and weaknesses, may be of value to these and other countries. Actually, I believe there is much that one can learn from the successes and failures of different peoples. Consequent with this belief, the concluding chapter, Chapter 6, deals with the possible relevance of at least some components of the

Swedish experience for the development of an infrastructure for national and regional health planning in the United States.

METHOD OF APPROACH

How is one to analyze the structures, processes and methods of national and regional health planning in any country, whether large, like the United States, or comparatively small, like Sweden? Some systematic approach has to be used in order to disaggregate such an undertaking into smaller and more manageable components.

Planning is just one function in the process of decision making, if we define the latter as the process of choosing goals and objectives, the selection of alternatives to be implemented, the implementation of the chosen alternatives, and the evaluation of this implementation.[1] There are, then, three major functions within this overall process: planning, implementation, and evaluation. Specifically, planning defines objectives and the possible alternatives for attaining them; implementation involves the actual execution of a chosen alternative; and evaluation involves determining to what degree a chosen alternative has achieved its objectives and analyzing the effects of its various components.

All of these elements are present in any decision, regardless of whether they appear explicitly as different sequential steps in the process of decision making or only implicitly.

Assuming, then, that these elements are present in decision making, we could analyze the structures, processes and methods of national and regional health planning by studying the structures, processes and methods of the different groups that are primarily responsible for them: the decision makers, the planners, the regulators, the administrators, the analyzers, and the data collectors. The study of who they are, what they do, and how they relate to one another provides a systematic approach for the analysis and appraisal of the political structure and process in Sweden (Chapter 1); the structure of its health services (Chapter 2); the structures, processes and methods of national and regional planning both outside and within the health sector (Chapters 3, 4 and 5); and the relationship between these (also in Chapter 3). A similar approach is used for a brief exploration of the planning process in the United States (Chapter 6).

In this scheme, *decision makers* are those who decide on the goals, objectives, and final plans to be implemented, and have the first and last word on all policy decisions. *Planners* are those who prepare the

actual plans; they define the concrete objectives and alternative means to reach them from which the decision makers will choose, and, moreover, they make explicit the consequences of choosing a given alternative. *Regulators* are those who assure and check the implementation of the final plan by the *administrators,* who execute the policies and plans chosen by the decision making group. *Data collectors* are those who assemble the information generated in the process of plan implementation, collecting and processing such data as are relevent to the planning, evaluation, and administration of the system. Finally, *data analyzers,* or research and development groups, are those who evaluate, analyze and develop new alternatives within the health services system.

This categorization, which is explained in more detail in the body of the text, is not normative but explicative. It is recognized as a somewhat arbitrary classification, since the distribution of responsibilities between groups and functions is not as clear as these initial definitions may imply. They are used, however, as points of reference that have been helpful to this writer and, it is hoped, will be of equal assistance to the reader in offering a conceptual framework for the analysis of the different groups and functions within the processes of decision making and planning at the national and regional level, outside and within the health sector.

SOME NOTES ON THE HISTORICAL DEVELOPMENT OF THE SWEDISH EXPERIENCE AND ITS RELEVANCE TO OTHER DEVELOPED SOCIETIES

Even though great differences exist among the health services of the industrialized societies, there are some common experiences or situations, three in particular, that are the result of similar pressures and historical forces. One is the ever rising cost of medical and hospital care, a combined result of constant technological innovation in the health sector, rising standards of living, and increased demand for services. Another is the effect of chronic morbidity on the structure, organization, and planning of health services. A third trend shared by these societies is the incipient but growing demand for popular participation in decision making in the health sector. Doubtless, the study of these phenomena in one society should prove of great benefit to others of similar structure. There is a saying in folk wisdom, "When your neighbor's house is on fire, put water on your own."

In Sweden, the rising cost of health in the decade 1960–1970, particularly in the hospital sector, has prompted a concern by the

national authorities (which regulate the hospital system) and the local authorities (which own and fund the major part of that system) for coordinating hospital services, particularly the more expensive tertiary care services. The formation of the Royal Commission on Regionalization, in the late 50's and early 60's, was the initial step in encouraging the regionalization of hospital services, in particular the coordination and planning of tertiary care services on a regional basis. The Swedish response to rising costs, then, was planning, coordination, and regionalization based on a voluntaristic approach; disparate groups with varying degrees of power were supposed to reach a consensus. The main debate both at national and local levels was amongst planners concerned with the waste of resources, politicians concerned with costs but also sensitive to the influence of pressure groups, and, last but by no means least, the medical profession, which is clearly oriented toward the hospital, and one of the most powerful pressure groups. Voluntarism in Sweden, as has been said by others of the United States, meant the prevalence and indeed the strengthening of the power structure and the status quo. Contrary to general belief, hospital regionalization in Sweden was, in the 1960's, irregular and limited in that it was to a certain degree implemented for tertiary care services as well as for some services in the rural areas, but of very limited effect in the urban areas. Different reasons may be postulated for this, but, as will be discussed more fully in the body of this monograph, political variables are of paramount importance in explaining this situation.

It was only in the late sixties that, primarily because of considerable unrest among the populace over ever increasing local taxes, local and national politicians and planners began to use the national and local planning machinery to redefine the balance of influences and consequently priorities. With respect to facilities, ambulatory care began to be recognized and given priority over hospital care, which consumes a major share of local taxes; with respect to human resources, recognition and priority were given to the primary care physicians over the secondary and tertiary care specialists. The assumption underlying these shifts in emphasis was that the suggested alternatives were less costly than the policies in effect at the time. Also, the planning machinery was strengthened and the voluntaristic approach was somewhat diluted, and major emphasis placed on control and regulation in the planning process. And the political and public planning bodies, which, in the 1960's had been under considerable influence from pressure groups, primarily the medical profession, started reassessing their own independence and began resetting priorities within the system in the early 1970's.

The conclusion that can be drawn from this situation may be relevant to the present debate in the United States as to whether market forces or a more direct and normative approach should be taken to restructure the health services system. One of the arguments for the former and against the latter approach is that the public regulating and planning bodies are, almost by definition, controlled and regulated by the providers, i.e., by those who are supposed to be regulated. The proponents of this argument broadly refer to the European experience in support of their view and assume, without much in the way of detailed analysis or rationale, that this experience confirms their fears. Actually, Swedish experience with planning bodies shows that although these are subject to the influence of the providers, their influence is affected by other groups which compete with the providers and which may displace or neutralize their effect in the "corridors of power." Thus, to the degree that costs become an ever more important political concern, the influence of the medical profession, although still strong and powerful, is increasingly balanced and even neutralized by the politicans' responsiveness to popular pressure to cut costs and control taxation.

If the 1960's in Sweden were marked by voluntarism in planning of the health sector, and by the intent of regionalization in the hospital services, the 1970's are characterized by strengthening the planning machinery at the national level, and by the intent of integrating ambulatory with hospital services and both of these with social services. Integration of these services is required inasmuch as the prevalent type of morbidity is chronic, and here we encounter the second common characteristic of developed countries; i.e., the effect of chronic morbidity on the structure, planning and organization of health services. Where chronic morbidity is prevalent, the tasks of the health services involve care more than cure of the population. In most industrialized societies, however, this care is provided on a piecemeal basis by separate types of services, usually under the jurisdiction of different administrations. In Sweden, the majority of personal (so-called curative) health services are the responsibility of the county authorities, while the preventive and social services are mainly the responsibility of the different bodies in the municipalities. The integration of these services will not be painless and has met with considerable resistance by the political and professional constituencies of these services.

The national health authorities in Sweden, however, today consider the task of integration to be one of the great challenges in the planning of health services. Reflecting this concern, some pilot experiments have been established which, it is hoped, will constitute

the first step toward the integration of health services; the success of this venture could constitute the trademark of the health services in the 1970's.

A third aspect often debated in most industrialized societies is that of the demand for popular participation in the decision making process in the health sector. Indeed, the goals and objectives of the health services in those countries have been slowly expanded to include not only the minimization of mortality and morbidity, but also the maximization of the people's satisfaction with their health services. Satisfaction, here, is to be interpreted not only in terms of the receiving end of the process of care and cure, people as patients,[1] but also in terms of the incipient stages, the decision making for that process; that is, people as participants in the decision making process in the health services system.[2]

Several reasons can be postulated for this demand; one not much explored as yet is the effect that the change in morbidity has had on the change in the decision making process. Indeed, most of the health services today, as White[3] has indicated, are involved more in care than cure, and in this area people are increasingly reluctant to delegate the monopoly of "expertise" in the art of care (as opposed to cure) to the medical profession. It can be argued that the medical profession which, due to what McKeown[4] calls the biological engineering approach in medical education, is educated more in how to cure than how to care, should share the responsibility for deciding how to take care of both individuals and communities, not only with the other professionals and paraprofessionals, but also with the lay public. Actually, the recent interest in the United Kingdom[5] and the United States[6] in community participation in the management of

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[1] There already exists a substantial body of literature on evaluating the health services according to patients' satisfaction with the care received. In the United States, a recent study is by C. S. Houston and W. P. Pasanen, "Patient Perceptions of Hospital Care," in which hospital care was evaluated according to, among others, the degree of satisfaction of the patient with different components of that care.

[2] For further discussion of this point, see G. Silver, "Community Participation," and C. Kirk, "Management and Community Participation."

[3] K. L. White, "Organization and Delivery of Personal Health Services: Public Policy Issues."

[4] T. McKeown, "An Historical Appraisal of the Medical Tasks."

[5] The consultative paper on reorganization of health services in the United Kingdom, for instance, proposes the establishment of community health councils to advise the area health authorities and district authorities in the management of the unified health service. The present debate in the United Kingdom over these councils questions what advisory means and for how much advice, and even control, this council should be responsible. See C. Kirk, op. cit., for further elaboration of this point.

[6] In the United States, every national health insurance proposal contains different recommendations for the establishment of similar community health councils, with the degree of influence and even control varying from proposal to proposal. See D. A. Kinding and V. N. Sidel, "Impact of National Health Insurance Plans on the Consumer."

the health sector is an indication that people's wants and satisfaction are being considered as objectives of the health services system; the public appears reluctant to delegate exclusively to the professionals the understanding and definition of its wants and satisfactions.

Worth noting is the argument, which is not without merit, that in those countries where, as in Sweden and Great Britain, the health services institutions are publicly owned, administered, and funded, citizen participation takes place through the normal political structures via the normal electoral process, on the assumption that those structures are responsive to the public's wants. However, the demand for community and citizen participation goes beyond this to include the democratization not only of the political process, but also of the working, recreational, and services institutions. The demand for community and citizen participation in the running of those institutions that affect the lives of the people is an undercurrent that undoubtedly affects, for the better according to some and for the worse according to others, the nature of the decision making process in the health sector.

Community and citizen participation in the health sector, which is very much a part of the political scene of the United States, and to a lesser degree of the United Kingdom, is not yet part of the Swedish experience. Indeed, it can be hypothesized that one reason for this is that the Swedish health services are administered directly by the local authorities, and that they are already responsive to the wants of the public. Still, in other fields of endeavor outside the health sector but within the public sector, such as urban planning, a demand for popular participation has arisen recently, particularly in large cities, and, as S.S. Passow[7] has noted, the planners are discovering "People Power." Is this a foretaste of things to come in the health sector?

Having introduced three aspects that define common characteristics at a certain level of social and health development, I leave it to the reader finally to decide how relevant the Swedish experience with national and regional health planning may be to his or her own environment. My conclusions and suggestions are the result of my perceptions only. I would add that if my notes on this relevance are not only justified but can stimulate greater interest in, and appreciation of, international health studies, I will feel more than rewarded for having written it.

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[7] S. S. Passow, "Stockholm's Planners Discover 'People Power'."

Chapter 1

THE ELEMENTS OF GOVERNMENT IN SWEDEN

Planning is one of the terms frequently used, but often ill-defined, in current socioeconomic literature. According to this author,

> . . . planning is a function in decision making and the latter is defined as the process of choosing goals and objectives, selecting the alternative to be implemented, and effecting its actual implementation. Within this overall process are included the three functions of planning, evaluation, and implementation. Specifically, planning defines objectives and the alternatives to reach them; evaluation involves determining to what degree the alternative chosen has achieved its objectives and analyzing the effect of its various components; and implementation involves the actual carrying out of the chosen alternative.
>
> According to these definitions, all of these elements are present in any decision, regardless of whether they appear explicitly as different sequential steps in the process of decision making or if they are only implied.[1]

Considered nationally, the steps within the process of decision making are not clearly delimited, and their development does not follow a clear-cut sequential or cyclical pattern. But as a categorization of different functions within government, it will be helpful to use these stages of the decision making process as points of reference to describe the levels of Swedish government with major responsibility for each stage. Section I of this chapter deals with decision making in national policy by the Parliament, Cabinet, and the Ministries, and the planning and implementation of policy by the various agencies. Using the same categorization, Section II describes the re-

[1] V. Navarro, "The City and the Region; A Critical Relationship in the Distribution of Health Resources," 882.

sponsibilities of and the relationships among the different groups of decision makers, planners, and administrators at the local level of Swedish government, i.e., the county and primary communes.

Government and the public sector are the subject of this chapter, because health services, personal as well as environmental, are the responsibility of the public, not the private, sector in contemporary Sweden.

Section I

THE NATIONAL LEVEL

THE DECISION MAKERS: THE PARLIAMENT

Responsibilities

The Parliament, or Riksdag, has power over legislation, the budget, foreign affairs, and the supervision of administration. According to the Constitution, matters relating to taxation and appropriations fall within the exclusive province of the Parliament, which also exercises direct control over the Bank of Sweden and the National Debt Office. In practice, however, as will be described later, the Parliament basically accepts the budget proposals of the executive, and its supervision of the administration is somewhat limited by the administration's autonomy.

Structure

Until recently, the Swedish Parliament had two Houses, equal in power but different in composition, size, and method of election. The Upper House (called the Första Kammaren, the First Chamber) was elected by the county councils (Landsting) or, in Stockholm and Göteborg, by the city councils (Stadsfullmäktige). The term of office was eight years and the membership of 151 was renewed successively. The Lower House (Andra Kammaren, the Second Chamber) was directly elected by the people in 28 constituencies, based on county councils and cities. The term of office was four years and

all 233 members had to be residents of the constituency in which they were elected.[2]

Originally, beginning in 1866, the Upper House was a bastion of wealth and privilege due to the income and property requirements for membership and voter eligibility. Correspondingly, it represented a conservative philosophy aimed at defending the interests of the land-owning aristocracy. As a result of political pressure by the expanding bourgeois and working classes, which grew in direct proportion to the development of industry, the economic qualifications for voters for and members of the Upper House were abolished, and until 1970 its membership was elected by the entire voting population, although indirectly, by proportional representation.[3]

Thus, the factors determining the differences between the two Houses were indirect elections, the longer period of service, the successive renewal of members, and the absence of a legal residence clause for the Upper House. It was a reflection of these differences, for example, that changes in public opinion made themselves felt more slowly in the Upper House than in the Lower House and the Upper House was represented as a check against abrupt changes. The growing homogeneity and stability of Swedish society, however, made the existence of such a "safeguard" seem unnecessary, and according to the 1967 Royal Commission on Constitutional Reform, even undesirable.

Since January 1, 1971, Parliament has consisted of a single chamber with 350 members, elected every three years.

Socioeconomic Composition

What is the composition of the Swedish Parliament? All members are at least 23 years of age, and most of them are over 50. The majority are members of local authorities, either county councils or municipalities; they are male—only 40 Members of Parliament are women—and they represent varied trades and professions, the most frequent of which are teachers and journalists.[4] Worth noting is that unlike most other western countries, in Sweden civil servants may stand for Parliament. This situation partly reflects the great autonomy

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[2] There are several publications outlining the functions, responsibilities, and structure of Parliament. To mention just a few: *Samhälle och Riksdag;* N. Andrén, *Modern Swedish Government;* P. Vinde, *Swedish Government Administration: An Introduction.*

[3] For an interesting analysis of the process of political democratization of the Swedish system of government and its relationship to the class structure of Sweden, see G. Therborn, "Power in the Kingdom of Sweden."

[4] J. B. Board, Jr., *The Government and Politics of Sweden,* 123.

of the Swedish civil service and is largely due to the historical dominance and active participation of civil servants in national politics, a legacy of the 19th century when they shared control over the First Chamber with the land-owning aristocracy.[5] Today, when a civil servant is elected to Parliament, his salary is adjusted accordingly, and he does not perform administrative duties while Parliament is in session. There is no requirement, however, that he resign his civil service position if elected. Table 1 shows the backgrounds of the Members of Parliament in 1961.

The Electorate

Every Swedish citizen over 20 years of age and not under special custody is entitled to vote as long as he is listed in the Register of Electors. This register is compiled annually by the local authorities and the individual citizen need not take any steps to be included in it. In terms of popular participation in elections, there are variations in the degree of participation by different sections of the population. Persons with higher incomes are more active voters—96% of this group voting in 1960, compared with 70% of the low income group. Married men are more active voters than married women, while among the unmarried, the reverse is true. Generally speaking, electoral participation is highest in the 40–49 year age bracket. Sweden's national average voter turnout compares favorably with that of other countries. In 1960, for example, voter participation in Sweden was 85.9%, compared with an estimated 60% participation of registered voters in national elections in the United States. As Rosenthal has noted:

> The significance of the differences between the percentage is especially striking in the light of the fact that all persons over 21 (since 1921 suffrage in Sweden has been universal) who are census-registered are automatically considered eligible to vote in Sweden.[6]

Who is elected? In 1968, the political composition of the electorate was 50% Social Democrat, 16% Center, 15% Liberal, 14% Conservative, 3% Communist, and 2% others. This voting profile was represented in Parliament by 204 Social Democrats, 60 Centrists, 60 Liberals, 56 Conservatives, and 4 Communists.[7] The corresponding figures in the 1970 election were 45.3% Social Democrat, 19.9% Center,

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[5] See *Samhälle, och Riksdag;* N. Andrén, *Modern Swedish Government;* G. Therborn, "Power in the Kingdom of Sweden."

[6] A. H. Rosenthal, *The Social Programs of Sweden,* 98.

[7] I. Wizelius (ed.), *Sweden in the Sixties.*

Table I. COMPOSITION OF THE SWEDISH PARLIAMENT BY PROFESSIONAL TRADE, AND CLASS BACKGROUND, 1961

I.	Cabinet ministers	13
II.	Public service, higher ranks	47
	Civil service	26
	Justice	3
	Defence	1
	Church	3
	Education and research	14
III.	Public service, lower ranks	26
	Education	9
	Other	17
IV.	Professions	129
	Law	4
	Medicine	4
	Press	33
	Religion	2
	Trade union (organizers)	11
	Party (organizers)	75
V.	Agriculture, etc.	88
	Proprietors	11
	Other farmers	69
	Fishermen	4
	Other	4
VI.	Trade, commerce, and industry	50
	Employers	28
	Salaried employees	22
VII.	Workers	13
	Public service	4
	Industry	9
VIII.	Housewives	17
Total		383

Adapted from: N. Andrén, *Modern Swedish Government* (Stockholm: Almqvist and Wiksell, 1968, rev. ed.), 72–73.

16.2% Liberals, 11.5% Conservatives, and 4.8% Communists, with parliamentary representation of 163 Social Democrats, 71 Centrists, 58 Liberals, 41 Conservatives, and 17 Communists.

In Sweden the electorate votes primarily for the party, rather than for the individual candidate. The candidates represent and are prac-

tically appointed by their national party leaderships. Also, there is a close correlation between voting patterns and social class. As Andrén has explained:

> The party structure of the electorate has been related to the traditional social group subdivisions of Swedish official statistics, consisting of three groups, I: employers and higher officials in large and middle-sized enterprises as well as salaried employees with a higher education; II: employers in smaller enterprises, farmers, other salaried employees; III: wage-earners. It was estimated that in the 1950's some 30 per cent of the Conservative voters belonged to group I, between 50 and 60 per cent to group II and the rest to group III. In the Center (Farmers') Party the overwhelming majority belonged to social group II, while the Liberal voters were more evenly distributed between the three groups, with a clear predominance of group II voters. Among the Social Democrats some 75 per cent of the voters belong to group III while the major part of the rest counted as group II. The Communists are almost exclusively supported by group III voters. With a slight oversimplification it would hence be possible to characterize the Conservative Party as predominantly an upper class party, the middle parties (Center and Liberals) as middle class parties, with varying emphasis on rural and urban support, and the two socialists parties as labor parties. The middle group obviously holds a key position in the party balance.[8]

As we will see later, to understand the political behavior of decision making bodies in Sweden, it is important to note the clear connection, indicated by Board, between Members of Parliament and the particular "pressure groups" they relate to as well as their political party.[9] For instance, the Swedish Association of Farmers, representing 2.4% of the Swedish population, holds 21% of the seats in Parliament.[10] The significance of this pattern will be analyzed later in this chapter.

The New Parliament

The 350 seats of Parliament are divided into two groups for electoral purposes. Three hundred and ten are known as constituency seats, to be distributed between the parties according to the vote in each constituency; the remaining 40 are compensatory seats, distributed to achieve proportional representation in accordance with the national vote. To be eligible for seats in Parliament, a party must obtain at least 4% of the national vote, that is, 14 seats, or 12% of a single constituency, that is 1–3 seats, depending on the constituency.

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[8] N. Andrén, *Modern Swedish Government*, 38–39.
[9] J. B. Board, Jr., *The Government and Politics of Sweden*, 63.
[10] N. Elvander, *Intresseorganisationerna i Dagens Sverige*, 197.

As previously mentioned, the Swedish electorate votes not for individual candidates in each constituency, but for the party. Thus the Member of Parliament elected by a constituency is not directly accountable to his constituents, as he is in the United Kingdom or the United States, but to his national party. This partially explains why citizen complaints against the government are made, not to local Members of Parliament, but either to the national leaders, to the press, or to the ombudsman.

The method of electing Members of Parliament follows a formula of proportional representation that favors the majority parties and discriminates against minority parties, above all the Communist Party.

Because Swedish Members of Parliament are primarily accountable to their parties and their national leaderships, a set of relationships has evolved in the Swedish system that affords the party leaders much greater power than is true for the American system. In fact, the most important post in Parliament is that of the party leader. As in the United Kingdom, he leads the government when the party is in power and heads the opposition when the party is out of power. Also, this pattern of accountability explains much of what happens in Parliament when, as a result of agreement between leaders of the main parties, a situation is created that has been criticized as "party leader dictatorship." [11] Such agreements, however, are tentative, not definitive, as final agreements depend on the bargaining process that usually takes place in the standing parliamentary committees, with final decision and approval by the parties occurring in plenary sessions of Parliament.

The Parliamentary Committee System, With Special Reference to Health Planning

Probably the most important single characteristic of the Swedish Parliament is its system of standing committees, shown in Table 2.

The committees differ from those of most parliaments in that their general structure, form, and functions are described and regulated by the Constitution as well as by statutory law and house rules.[12] Thus, a change in their structures and functions may require a constitutional amendment rather than ordinary legislation.[13]

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[11] I. Amilon, "Partiledarkonferenserna – en Studie i Parlamentarisk Praxis."

[12] For a comprehensive review of the literature, see R. Malmgren et al, *Sveriges Grundlagar och Tillhörande Författningar med Förklaringar.*

[13] N. C. M. Elder, "The Parliamentary Role of Joint Standing Committees in Sweden."

Table 2. PARLIAMENTARY STANDING COMMITTEES

Standing Committees on:	
The Constitution	Education
Finance	Transport
Justice	Conservation and Agriculture
General Legislation	Industry
Foreign Affairs	Labor and Housing
Defence	Physical Planning and Local Government
Social Insurance	
Social Affairs	
Cultural Affairs	Taxation

Note: Only the Committees on the Constitution and Finance are explicitly called for by the Constitution. The others are set up at the direction of the Parliament. The Committee on the Constitution is responsible, inter alia, for examining the constitutional and legal aspects of Government decisions. The other Committees have been organized to correspond to the whole or part of the field of responsibility of the corresponding Ministry. Each Standing Committee consists of 15 regular members plus deputies.

Adapted from: P. Vinde, *Swedish Government Administration: An Introduction* (Stockholm: The Swedish Institute), 61.

All bills are referred to committee before being discussed by Parliament. In the past Parliament, the most important committees in relation to health services and health services planning, in addition to the Committees on Social Affairs & Social Insurance, were the following:

1. The Committee of Supply (statsutskottet) or Appropriations Committee, composed of 30 members and one of the two main committees responsible for the budget. It was probably the most powerful committee in the Parliament. Its chief concern was with state expenditures, and its power thus touched on almost the entire state administration. It was divided by its work into five divisions: Defence, Church and Education, Social Welfare, Communications Systems and Investment, and Pay and Pensions.
2. The Committee of Ways and Means (bevillningsutskottet), composed of 20 members. It was charged with responsibility for taxation and matters relating to alcohol. For working purposes, it was divided into two subcommittees, one of which dealt with indirect taxes, customs, stamp duties, and the like, and the other mainly with direct taxation.
3. The Committee on Banking (bankoutskottet), consisting of 16 members, and with jurisdiction over banking laws, and supervision of that part of the administration which was directly responsible to Parliament (e.g., the Bank of Sweden).

It also dealt with those general economic questions which were not within some other committee's competence.[14]

Formerly, in health as in other areas of legislation, when a proposed bill contained revenue measures, it fell within the jurisdiction of the Standing Committee on Ways and Means, whose responsibilities were similar to those of the House Committee on Ways and Means and the Senate Finance Committee in the United States. When a proposed bill referred to matters of licensing, organization, or regulation, it fell within the jurisdiction of the Standing Committee on Social Affairs. Comparable bodies in the United States are the Senate Committee on Labor and Public Welfare and its equivalent in the House. In 1971 these two Swedish committees were restructured into two new committees, the Standing Committee on Taxation and the Standing Committee on Finance. Their respective functions, however, remained the same.

Each committee has approximately 20 members, representing all parties except the Communists, in proportion to their overall parliamentary strength.[15]

The average committee member has approximately 10 years service on the committee. As in the United States Congress, party nominations to the committees are usually, but not always, determined by seniority. Theoretically, committees elect their own chairmen, but in practice this decision is made by agreement among the leaders of the various parties. Unlike the United States, the post of chairman carries little power in itself.

Committee meetings are not open to the public, and no hearings are held in the American sense. No minutes are kept, and only the final results are published in the committee reports.[16] Cabinet members are not eligible to serve on committees and cannot appear before any committee except the Committee of Foreign Affairs.

The committees select their own staff, usually comprised of civil servants from those government agencies (equivalent to the departments in the United States federal government) within the field of interest of the committee. This interaction between government agencies and parliamentary committees had been widely criticized, for it gave great power and influence to the agencies and put into question the impartiality of the civil service. Since 1966, however, this situation has changed considerably, and parliamentary committees are now entitled to hire their own staffs.

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[14] J. B. Board, Jr., *The Government and Politics of Sweden*, 132–133.
[15] J. B. Board, Jr., *The Government and Politics of Sweden*, 133.
[16] P. Vinde, *Swedish Government Administration: An Introduction.*

Similar to the United States congressional committees, the committees of Parliament undertake the detailed scrutiny and amendment of all proposals. It is during the committee stage, moreover, that agreements and compromises are reached between the political parties and groups in Parliament. The relationship between the committees and Parliament will be described later.

THE DECISION MAKERS AND POLICY PLANNERS: THE EXECUTIVE [17]

The Prime Minister and His Cabinet

The real political power in the Swedish parliamentary system resides with the Prime Minister and his Cabinet or Council of State (Statsradet); see Table 3. The members of the Cabinet are Members of Parliament, appointed by the Prime Minister to head the 12 Ministries, and six Consultative Ministers (Konsultativa Statsrad) or Ministers Without Portfolio, also appointed by the Prime Minister from among Parliament. Usually, two of the Ministers Without Portfolio are lawyers whose responsibilities include scrutinizing the legal and constitutional aspects of all Cabinet proposals to Parliament. Neither the appointment of the Prime Minister nor of the Cabinet members requires formal ratification by Parliament, in contrast to Cabinet appointments in the United States. Members of the Cabinet retain their seats and voting rights while serving as Ministers.

As in the United Kingdom, the Cabinet is a collective body and its decisions are held to represent the opinion of all its members. This principle of collective responsibility is formally reflected in the weekly meetings of the Cabinet with the King, where formal ratification of informal decisions takes place. On that occasion the Cabinet is referred to as the King in Council (Konungen i Statsrädet). These meetings are a mere formality, lasting just over half an hour, for the signature of all decisions. They are not public, but official minutes are taken.

The actual decisions are made in the Cabinet meetings (without the King attending), which convene several times a week, with no minutes taken. In addition to these Cabinet meetings, there are ses-

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[17] There are several references in both Swedish and English that detail the workings of the executive. Among the most comprehensive are: A. Tugelson, *Sa Regeras Sverige;* P. Vinde, *The Swedish Civil Service: An Introduction;* J. B. Board, Jr., *The Government and Politics of Sweden,* Chapter 6; and N. Andrén, *Modern Swedish Government,* Chapter 6.

Table 3. COMPOSITION OF THE SWEDISH CABINET

I.	Prime Minister
II.	Minister of Foreign Affairs
	Minister of Justice
	Minister of Defence
	Minister of Health and Social Affairs
	Minister of Transport and Communications
	Minister of Finance
	Minister of Education
	Minister of Agriculture
	Minister of Trade
	Minister of Labor and Housing
	Minister of Physical Planning and Local Government
	Minister of Industry
III.	Ministers Without Portfolio
	With special responsibility for Disarmament
	With special responsibility for Family Policy
	With special responsibility for Civil Service Affairs
	With special responsibility at the Ministry of Education
	Legal Consultants (2)

Adapted from: P. Vinde, *Swedish Government Administration: An Introduction* (Stockholm: The Swedish Institute, 1971), 18.

sions of an inner circle that usually consist of the Prime Minister and the Ministers of Finance, Defence, Health and Social Welfare, and Foreign Affairs.

Since 1953, there have also been regular meetings, sponsored by the Prime Minister, with leaders of the main economic organizations of the country. Most decisions concerning national economic policy are determined in these meetings. This process is referred to as "Harpsund democracy." [18] Recently, the frequency of these meetings has been decreasing as a result of growing concern about the possible implications of bypassing the parliamentary system.[19]

One of the Cabinet's main responsibilities is preparing the national budget and guiding it through Parliament. This responsibility *per se* makes the Cabinet one of the most powerful institutions in Sweden.

[18] Harpsund is the summer residence of the Prime Minister, where these meetings usually take place.

[19] *The Economist*, "The International Report."

The office of the Prime Minister has a small staff of ten—an Undersecretary of State, several personal secretaries, a press relations officer, and a few other staff members. The activities of the Ministers are coordinated by the Cabinet office, as well as by certain Ministries, primarily the Ministry of Finance through the five-year economic projections and the annual budget (see Chapter 3 on the planning process). Also, in recent years and in order to facilitate interministerial coordination, several cross-ministry councils have been established, such as the Education Planning Council, the Council on Regional Development, the Economic Planning Council, and the Health Planning Council. These are usually headed by Ministers or Undersecretaries—for example, the Health Planning Council is headed by the Undersecretary of Health and Social Affairs.

The Ministries, With Special Reference to the Ministry of Health and Social Affairs

A basic characteristic of the Swedish civil service at the national level is that it is organized at two separate levels—the Ministries (departements) and the agencies or boards (ämbetsverk). The former are responsible primarily for the framing of policy, and the latter for its execution.

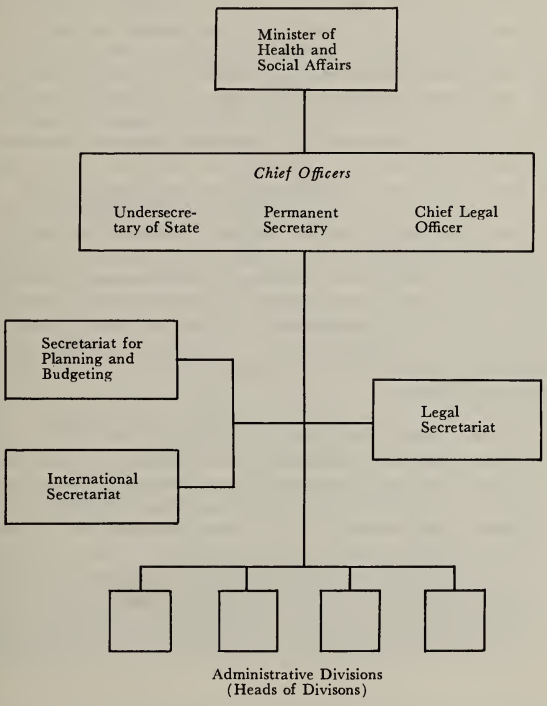
The Ministries or departments are in general relatively small policy making and coordinating bodies. They play a key role in the planning process, preparing most of the legislation to be presented to Parliament by the Cabinet and drafting supplementary regulations after laws are passed. In contrast, the agencies or boards are quite large and are responsible for implementation.

There are twelve Ministries, with the Departments of Health and Social Affairs, Defence, and Education consuming most of the annual budget. The Ministry of Health and Social Affairs was established in 1964 in its present form. Its predecessor had been the Ministry of Social Welfare, one of the oldest Ministries in the national government. In 1947, it was decided that this Ministry was too large and the Ministry of the Interior was created to take over the responsibility for civil defence, police, fire prevention, public health, and local government affairs. The Ministry of Social Welfare retained activities related to labor, insurance, housing, old age, and child care, and the alcoholism program. In 1963, a new law was passed that changed the distribution of functions between these two Ministries. Activities in the field of health were concentrated in the Ministry of Social Welfare, while labor and housing affairs were passed to the Ministry of the Interior. The reasons for this change and the

change in title of the Ministry of Social Welfare to the Ministry of Health and Social Affairs, in 1964, were very similar to the motivation for the creation of the United States Department of Health, Education and Welfare—namely, the need to coordinate the range of health and welfare programs and legislative proposals.

Figure 1 shows the organization of the Ministry of Health and Social Affairs, which is fairly representative of the organization of most of the Ministries.

FIGURE 1. ORGANIZATION OF THE SWEDISH MINISTRY OF HEALTH AND SOCIAL AFFAIRS



Adapted from: P. Vinde, *Swedish Government Administration: An Introduction* (Stockholm: The Swedish Institute, 1971), 20.

Directly under the Minister (Departementschef) there is the Undersecretary of State (Statssekreterare), who is a political appointee and the Minister's chief advisor on political and economic matters. He may or may not be a civil servant or a Member of Parliament. If he is not a Member of Parliament he is not allowed to speak before it. Next to the Undersecretary are the Permanent Secretary (Expeditionschef) and the Chief Legal Officer (Rättschef), both career civil servants and advisors to the Minister.

The Ministry has secretariats dealing with planning and budgeting, international affairs and legal affairs. The secretariats are quite small, with a great predominance of lawyers, usually under the age of 35. Service in the Ministry is usually of limited duration. It is customary for the staff of the Ministries to leave by the age of 40 or 45 and they rarely stay past 50. The rationale behind this policy is that the pace of work and the long hours are too demanding for persons over forty. Also, it is thought that the versatility and energy of younger people makes them ideal for policy-shaping positions.[20]

Most of the rest of the staff is organized into five administrative divisions, each of which is responsible for all policy within one of the areas under the Ministry: social insurance, social welfare, care of the handicapped, health and medical care, and miscellaneous.

In 1970, the total professional staff in the Ministry of Health and Social Affairs numbered 55, a size which is not uncommon in Swedish Ministries. Relatively small staffs are feasible because most of the research, study, and recommendations upon which policy is based are done by the Royal Commissions (see below) and other bodies, and also because the implementation of policy and day-to-day administration is carried on by various agencies, freeing the Ministries for policy-making roles.

The functions of the Ministries can be described as follows:

a. Policy planning, including drafting directives to the Royal Commissions, and preparation of the five-year economic projections of government income and expenditures, which are made annually and presented to Parliament each May (see Chapter 3 for the budget process);

b. Activities directed toward Parliament, including, as the most time-consuming activity, the drafting of all government bills. The major bill each year is the draft of the annual budget with the estimated income and expenditures for the coming fiscal

[20] Personal communication, Ministry of Health and Social Affairs.

year. Another activity in this field is that of drafting replies to questions raised in Parliament. Worth noting is that civil servants from the Ministries are very rarely asked to testify before parliamentary standing committees. Ministers cannot appear before those committees, but when required, the Undersecretary and/or the head of the responsible division of the Ministry can appear;

c. Activities arising from decisions taken by Parliament, including the drafting and issuing of supplementary regulations, as well as of detailed regulations on how allocations are to be spent by the respective agencies;

d. Preparing information for use by the King in Council in judging appeals from citizens and institutions against decisions made by the agencies. In the Ministry of Health and Social Affairs, the number of appeals is such that a separate group in the miscellaneous division has been set up, exclusively staffed by legal officers, to prepare the resolution of those appeals.

THE ADMINISTRATORS: THE AGENCIES

The agencies are the administrative branches of government in charge of the execution of policy at the national level. Although responsible and accountable to both the individual Ministries and to the Cabinet, the agencies enjoy a semi-autonomous position within the government. This autonomy is a legacy of the 19th century, when the nobility controlled the civil service and the Upper House of Parliament. With the rise of the Lower House, the nobility struggled to keep autonomy for the agencies, controlled by the land-owning aristocracy. The "noblesse oblige" attitude of Swedish nobility toward public service was clearly correlated with their defence of their political power. The nobility controlled the civil service, particularly the agencies, and the civil service controlled the Upper House. This tradition has now been largely eliminated,[21] although a considerable number of civil servants, particularly top officials, still come from the upper classes. This situation has caused some Social Democrats to complain that sectors of some agencies are not committed to social democracy. However, it is generally assumed that the gradual democratization of the school and university system will provide greater opportunities for the equalization of social class within the civil service.

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[21] J. B. Board, Jr., *The Government and Politics of Sweden*, 164.

Functions

The activities of the agencies are directed by their boards, which consist of a chairman, who is also the Director General of the agency, and laymen appointed by the King in Council for different periods of service. The lay members of the National Board of Health and Social Welfare are appointed for three years. The functions of the boards vary depending on the agency, but basically they provide overall guidelines in terms of the internal operation of the agency. In some instances, as on the National Police Board, Members of Parliament are appointed to the board to provide for parliamentary supervision and participation. Mostly, members are appointed from institutions and pressure groups related to the field of activity of the agency. For example, representatives of industry and labor are appointed to the Labor Market Board. Only recently, however, and as part of a movement referred to as "industrial democracy," have members from the staff of some agencies been appointed to their boards, for example, to the State Power Board. Similarly, a student representative has been appointed to the Board of Education.

The structure and composition of the National Board of Health and Social Welfare is the most frequent although not the only pattern.[22] There are, for instance, some boards with only one member, the Director General of the respective agency.

Under the Director General, there are different divisions, corresponding to the functions and responsibilities of each agency. These functional divisions correspond to policy at the ministerial level and execution at the agency level.

Once legislation is enacted, it is passed to the agencies for interpretation and application, within the framework set by the King in Council and the Ministries. In theory, all authority vested in the agencies is delegated by the King in Council.

In fact, however, the agencies and their staff have considerable flexibility in the interpretation of legislation. Each civil servant is solely responsible for the decisions he makes at the level and in the area delegated to him. This puts the civil servant in a situation similar to that of the judicial officer of a civil court. His decision is binding on the agency and can be reversed only if an appeal is made to the board of the agency and from there to the King in Council. It is the civil servant, and not the agency or the Ministry, who is held legally responsible for his decisions and actions, or lack of action.

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[22] The members of the National Board of Health comprise two representatives of the National Federation of County Councils, two representatives of the National Federation of Primary Communes, two Members of Parliament, and two university professors.

Moreover, civil servants cannot be removed from office without a trial in a civil court, providing a security of tenure that makes the civil service fairly insensible to outside pressure. Each civil servant thus enjoys a power and autonomy almost unparalleled among the western parliamentary systems. Furthermore, Swedish civil servants (including officers of the Armed Forces) are allowed to pursue political activities and run for office, and maintain their positions by getting a leave of absence when Parliament is sitting.

The division of executive authority into the two levels of policy and execution referred to previously is not clear cut. Ralph Miliband cautions that, ". . . to view higher civil servants (in the agencies) as the mere executants of policies in whose determination they have little or no share is quite unrealistic." [23]

Indeed, the role of the state in many modern industrialized societies has become one of running the economy. Correspondingly, the discretionary element in government legislation has increased, and the policy bodies of the executive are increasingly reluctant to risk distorting the political content contained in legislation by conferring responsibility to the agencies. For this reason, both the Ministries in Sweden and the United States White House staff and Cabinet officers have been attempting to recover authority for execution of policy that had been delegated to the agencies in Sweden and the federal departments in the United States.

The National Board of Health and Social Welfare

The National Board of Health and Social Welfare [24] was established in 1968, as a result of the consolidation of the Board of Health and the Board of Social Welfare. The rationale for this was to curtail the profusion of boards and integrate those boards dealing with interdependent and related areas.

Before this restructuring, the National Board of Health had been divided along lines similar to the structure of the United States Public Health Departments. The division was categorical and according to diseases, such as tuberculosis, venereal disease, cancer, and so forth, and by age and sex groups, e.g., maternal and child care. The new organization of the Board in six departments reflects different

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[23] R. Miliband, *The State in Capitalist Society: An Analysis of the Western System of Power*, 119.

[24] This board will be referred to subsequently as the National Board of Health.

functions; health care, short-term care, long-term care, planning, administration, and drugs.

The functions of the Board are to plan, supervise, and regulate the delivery of environmental and personal health services at the county council level.[25] Its structure is shown in Figure 2.

The head of the Department of Planning acts as coordinator and liaison for the other departments. The department has five divisions: medical manpower and education, general planning, medical statistics, emergency and wartime planning, and emergency staff registration. It is the department's responsibility to establish norms and standards for manpower and facility planning that must be observed by the county councils and primary communes. For example, all physician appointments in the public sector (made either by the county council authorities or by the National Board) must be approved by the National Board of Health in accordance with guidelines developed by the manpower division of this department (see Chapter 4 on national health planning for further details on this process). An additional function of the department is to store information on the human resources of the country.

The Department of Health Care contains three divisions: environmental, social care of children and adolescents, and dental care. The Department of Short-term Care contains four divisions: ambulatory care, hospital care, psychiatric care, and social care of drug and alcohol addicts. The Department of Long-term Care has four divisions: rehabilitation and long-term care, care of the mentally retarded, social and legal psychiatry, and care of the aged. The Department of Administration also contains four divisions: legal affairs, personnel, financial administration, and information, including public relations. Finally, the Pharmaceutical Department contains three divisions: general drugs, registration, and laboratory.

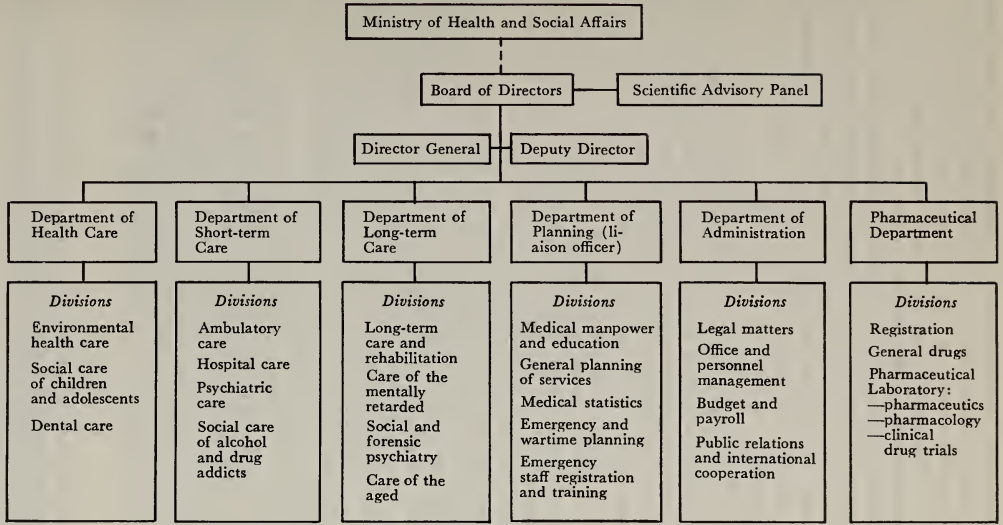
ADMINISTRATIVE RELATIONSHIP AMONG PARLIAMENT, THE EXECUTIVE, AND THE AGENCIES

The Legislative Process

Most of the legislation in Sweden is generated by the Cabinet (propositioner) with a few proposals introduced by private members of Parliament (motioner), and still fewer introduced by some stand-

[25] A succinct presentation of the functions of this agency is given in American College of Hospital Administrators, *The Swedish Health Services System.*

FIGURE 2. THE SWEDISH NATIONAL BOARD OF HEALTH AND SOCIAL WELFARE



ing parliamentary committees (the Constitutional, Ways and Means, and Banking Committees). Most committees do not have the power to initiate proposals.

The six different steps that are usually followed in the legislative process are described in the following.

A motion is presented by a Member of Parliament and referred to the appropriate standing parliamentary committee. After examination of the proposal, the standing committee usually requests that Parliament petition the government to appoint a Commission of Inquiry, or Royal Commission. The government usually complies with such requests.

The Commission of Inquiry (Utredningskommité) studies and makes recommendations to the government concerning the subject of the motion, with a draft of a proposed law. These Commissions are among the most active institutions in the Swedish government, and at any given moment there are hundreds of Royal Commissions dealing with a wide range of problems in Swedish society. In 1971, there were 2000 Royal Commissions, with an average life span per Commission of four years.[26] The government's directives are usually very general, and the latitude allowed the Commissions is quite broad. The time period allowed for their deliberations varies according to the subject of the motion being considered.

The nature, composition, and type of the Commissions vary considerably.[27] When the matter is primarily political, e.g., concerns constitutional reform, most Commission members will be Members of Parliament appointed by the government and the opposition parties. On other occasions, the Commission may consist of just one member, who may be a civil servant, a Member of Parliament, or a private citizen. An example was the Royal Commission on Regionalization of Health Services, whose sole and constituent member was the Director General of the National Board of Health.[28]

On some Commissions, members belong to the groups, organizations and "pressure groups" that may be affected by the actions taken on the proposal under consideration. In fact, it is frequently a deliberate policy of the Commissions to include the pressure groups (Chambers of Commerce, trade unions, and the like) to such a degree as to make them part of the parliamentary system itself. As one observer has remarked, " . . . rather than being pressure groups, in

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[26] Riksdagens Upplysningstjänst, *Sakregister 1971.*

[27] The most comprehensive study on Royal Commissions in Sweden is by H. Meijer, *Kommittépolitik och Kommittéarbete.*

[28] A. Engel, *Regionsjukvarden.*

Sweden today they are regarded as cornerstones of the political system." [29]

Obviously, other democratic governmental systems, such as those in the United Kingdom and the United States, are likewise not immune to the influence of such groups. In the United States, for instance, there is a large body of literature that describes, analyzes, and reflects concern about the influence of pressure groups on the legislative process by lobbying [30] and on the informal and formal advisory committees to the executive.[31]

The unique aspects of the Swedish system are the formalization of this influence, and the significance of the work of the Royal Commissions as a basis for policy making. Actually, the great power that these interest groups have in drafting proposed legislation has been questioned recently as possibly biasing the nature of such legislation for the benefit of those groups, to the extent of interfering with the democratic nature of the legislative process. At least partly in response to this concern, the relative importance of the Royal Commissions as generators of information and policy has been somewhat reduced in recent years. And there has been a corresponding increase in the importance of the Ministries, which have come to take over more and more of the research and policy functions of the Commissions. For example, the information required for a major reform of national health insurance in 1971, the "seven kronor reform" (see Chapter 2), in which the procedures governing patient payments and physician salaries were changed, was researched and formulated in policy recommendations made by the Ministry of Health and Social Affairs. A Royal Commission was not appointed for this purpose.

The findings of the Royal Commissions are published in a series of volumes referred to as Government Official Investigations, or SOU (Statens Offentliga Utredningar). These reports are distributed by the government for review and comments to the agencies, institutions, and private interests that will be affected by the proposed legislation. In Sweden this process is referred to as 'remiss.'

After receiving the comments on the Commission's report, the corresponding Ministry prepares the bill to be submitted to Parliament subject to approval by the Cabinet.

After a brief discussion in Parliament, the bill is sent to the corresponding standing committee, where it cannot die but has to be

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[29] T. Hermansen, *Case Studies on Information Systems for Regional Development, Volume I: Sweden.*

[30] *The National Journal Intelligence File,* "The Pressure Groups."

[31] *Washington Monthly.*

reported back to Parliament. Significantly, some civil servants from the Ministries or the agencies who serve as staff to the Royal Commissions may work as staff also in the parliamentary committees.

After amendments have been made and the bill has been approved by the standing committee, the committee reports back to Parliament. A unique feature is that the Parliament can vote only on the bill in its totality as agreed upon by the committee and can neither offer amendments nor approve it only partially. As a result of this process, and because most decisions are likely to have been made in committee or by interparty agreement, the parliamentary debate has been perceived by some observers as being of lesser importance in Sweden than in other parliamentary systems. Also, due to the accountability of each Member of Parliament to his party rather than to his constituency, he has little need for speaking for the record and his constituents. As Board summarizes in his perceptive remarks on the Swedish Parliament, " . . . all these conditions may explain the lack of drama" [32] in parliamentary debates.

ADMINISTRATIVE RELATIONSHIP BETWEEN PARLIAMENT AND THE AGENCIES

The Ombudsmen and the Parliamentary Auditors: Implications for the United States

Unlike congressional committees in the United States, the Swedish parliamentary committees do not act as watchdogs or as supervisory bodies of administrative agencies. Indeed, as the agencies are in principle independent of Parliament and not subject to its direct pressure or influence, questions concerning particular administrative decisions made by the agencies cannot be raised in those committees.[33]

There are, however, two parliamentary bodies that do have supervisory responsibilities over the agencies—the Parliamentary Commissioners, or ombudsmen, and the Parliamentary Auditors.

Ombudsmen, according to a recent official Swedish publication, " . . . are the watchdogs of the Parliament over the civil servants and the courts." [34] Their office was created in 1809 by a constitutional amendment, during a period in which the civil service had great

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[32] J. B. Board, Jr., *The Government and Politics of Sweden*, 140.
[33] P. Vinde, *Swedish Government Administration: An Introduction*, 63.
[34] Ministry of Finance (Sweden), *The Swedish Budget 1967/1968*.

power and autonomy.[35] It was the intention of Parliament to create controls over the civil service for the purpose of " . . . supervising the observance of laws and statutes as applied to all matters by the courts and by the public employees." [36]

Ombudsman means simply "representative." The full Swedish title is "justitie ombudsman," or "representative of justice," usually referred to in English as the "Parliamentary Procurator for Civil Affairs," and referred to by Swedish citizens simply as "JO." There are three ombudsmen and they are appointed by Parliament every four years, with the incumbents expected to serve two or possibly three terms. The holder of this office is responsible to the Standing Parliamentary Committee on Law, to which he submits an annual report. These reports provide a good insight into the actual workings of the office of the ombudsman.

Actually, the prestige of the ombudsmen is disproportionate to their rather limited powers. They can gather facts, prosecute, criticize, and make recommendations on the work and decisions of almost all government employees. This includes all central and local government functionaries except Cabinet Ministers, and the courts, including the Supreme Court. The ombudsmen cannot, however, intervene to change a decision once it has been made.

When gathering facts, the ombudsman has almost complete access to information from civil servants and from the files and records of the courts and agencies. The ombudsman can prosecute almost any employee of the government and courts, but this prerogative is very rarely exercised. More frequently used is criticism, ranging from an official reprimand, whose purpose is largely educational, warning an official not to repeat an error, to a simple statement of critical opinion. In 1966, for instance, the Director General of the then National Board of Health was reprimanded by the ombudsman for holding a part-time job with a leading insurance company without having obtained the formal permission of the government. Although the Director General had the verbal permission of the appropriate Ministry and the Cabinet, the ombudsman felt that this informal arrangement did not free the Director General from the responsibility of making a formal request.[37] Besides this, the ombudsman questioned whether ranking

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[35] The ombudsmen were expanded in 1914 to include a military ombudsman. A complete description is given in H. Henkow, "The Ombudsman for Military Affairs."

[36] Because of the great interest in the concept of the ombudsman outside Sweden, there is a large bibliography on that institution, mostly in English. Recommended references are: D. Rowat (ed.), *The Ombudsman;* W. Gellhorn, *Ombudsmen and Others;* and S. V. Anderson, *Ombudsman for American Government?*. A succinct description of this office from a Swedish governmental point of view is in A. Bexelius, *The Swedish Institution of the Justitieombudsman.*

[37] F. Fleisher, *The New Sweden: The Challenge of a Disciplined Economy.*

executives of the National Board of Health should hold any jobs with insurance companies, as there could be a conflict of interest. This situation, where top executives of the Board hold part-time consultant appointments to nongovernmental institutions, still persists today.

In addition to gathering information, prosecuting, and criticizing, the fourth possible action of the ombudsman is to recommend changes in the law to the Standing Parliamentary Committee on Law.

The ombudsmen have a staff of six lawyers. The information they receive comes primarily from three sources: (1) from citizens' complaints; (2) from articles in the press; and (3) from their attendance at governmental deliberations, including the Supreme Court and the Supreme Administrative Court.

> In 1964, 1429 cases were received by the ombudsman. Of these, 1239 were complaints from citizens, 179 were initiated as the result of investigations and inspections instituted by the ombudsman, and 11 resulted from items or information appearing in the press. Of these cases, 381 were dismissed without further actions for such reasons as not coming within the authority of the ombudsman, misunderstanding of the law by the complainant, and similar reasons. The complainants withdrew 12 cases. After inquiry, 722 cases were dismissed. This disposed of 1115 cases. Action by the ombudsman on the remaining cases resulted in 283 admonitions, 3 referrals to other authorities for action, 2 prosecutions, and 7 recommendations for new legislation or regulations. Eighty-three percent of the cases were disposed of within a period of six months after their receipt.[38]

A similar picture is presented in the 1971 Annual Report of the Ombudsman. Out of 2893 cases, only 3 were followed by prosecution. Most of the cases were dismissed.[39]

It is important to note that most public complaints concern social services, particularly health services, and are directed toward civil servants at the local level.[40]

To what degree do the ombudsman serve as watchdogs over the government bureaucracy and courts? It would seem to an outside observer that the rather limited resources of the ombudsman and the large size [41] and great autonomy of the bureaucracies may limit their efficacy as a watchdog mechanism, particularly in view of the almost total absence of any of the other control mechanisms that exist in other countries. Indeed, the rather small number of cases considered,

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[38] A. H. Rosenthal, *The Social Programs of Sweden*, 125.

[39] Justitieombudsmännens Ämbetsberättelse, *The Swedish Parliamentary Ombudsmen: Annual Report for 1971.*

[40] Personal communication, Ministry of Health and Social Affairs.

[41] There are 43 central government employees for every 1000 employed persons, as opposed to 34 per 1000 in the United States.

for instance, 1859 cases in 1965—less than .02% of the Swedish population—with only four prosecutions, may be an indicator of the ombudsman's limited ability to control those bureaucracies. This may explain why the value of the ombudsman has been considered as being mainly psychological and as lying in " . . . simply the fact that such an office exists and government officials are conscious of its existence." [42] More critical observers, however, have considered the ombudsman as a mere legitimization of a system that perpetuates the limited supervision and control of the civil service by the government.[43]

Complementing the supervisory functions of the ombudsmen are the twelve Parliamentary Auditors (statsrevisorer), who are responsible for " . . . the inspection of the state and the direction and administration of the Exchequer." [44] They are elected by Parliament from among its members. Their powers are limited to issuing reprimands in cases of "wrong doing" on the part of the civil service and the courts.[45]

To analyze the possible value of the office of ombudsman for other countries, one must consider the peculiar characteristics not only of that office but also of the Swedish conditions that determine it. First, as indicated above, the Swedish civil service is autonomous, not accountable or responsible to Parliament. The parliamentary standing committees do not act as watchdogs, in the American congressional committee sense, of the government bureaucracy. The only parliamentary control is through the offices of the civil and military ombudsmen, who have rather limited resources, and their strongest power is that of prosecution, which is very rarely used. Also, as noted by Board:

> It is important to remember that the Government does not exert any specific control over the administration, which acts according to the law. It is in the resulting vacuum that an official like the J. O. (who reviews the actions of administrators but not those of policy makers) may be not only useful but necessary.[46]

Another relevant aspect of the Swedish political system is that Members of Parliament are not accountable directly to their constituencies. A citizen who would take his grievances to his Member of Parliament in the United Kingdom, or to his Senator or Representative in the United States, would, in Sweden, appeal to the ombudsman.

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[42] A. H. Rosenthal, *The Social Programs of Sweden*, 126.
[43] Personal communication, G. Therborn.
[44] P. Vinde, *Swedish Government Administration: An Introduction*, 64.
[45] *Ibid.*, 65.
[46] J. B. Board, Jr., *The Government and Politics of Sweden*, 185.

In summary, the office of the ombudsman is required within the Swedish administrative system to provide a counterweight to the political power of the civil service.

In spite of the uniqueness of the Swedish situation, the concept of ombudsman continues to be discussed as being of possible application in other countries. Actually, Denmark, Norway, New Zealand, the United Kingdom, and Tanzania have created similar offices. In the United States, bills proposing such an office have been introduced in both Houses of Congress and in several state legislatures.

Actually, the General Accounting Office in the United States (which reports to Congress) has some responsibilities similar to those of the Swedish ombudsman. The General Accounting Office provides a close and careful review of government expenditures, both for conformity to existing laws and for use of proper procedures and judgment.[47] Also, the congressional committees (as well as individual members of Congress) have a certain degree of responsibility for the supervision of the corresponding federal departments. The responsibilities of the ombudsman, however, seem to be broader and this difference may explain the continuing concern and demand of legislatures, at the federal, state, and even local levels, for establishing an agency where the "man in the street" could question the appropriateness of government bureaucracy decisions. For instance, in 1963, Congressman Reuss [48] introduced a bill in the House of Representatives to provide for an administrative council to which private citizens could send their grievances and complaints for consideration and possible correction by the Federal Government because ". . . the increasing complexity of the Federal Government has created difficulties on the part of private citizens in dealing with the Government." An identical bill was introduced, in 1965, by Senator Pell.[49]

The councils proposed in both bills differ from the Swedish ombudsman in that complaints would be channeled through the members of Congress who could, at their discretion, pass it to that body, parallel to the newly established Parliamentary Commissioner in the United Kingdom. Such a channeling of complaints through members of Congress or Parliament has been criticized as allowing for the possibility of politically motivated action rather than the supposedly nonpolitical action of the Swedish system.

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[47] A. H. Rosenthal, *The Social Programs of Sweden*, 126.

[48] Congress of the United States of America, 88th Congress, First Session, H.R. 7593, Section 2 (July 16, 1963).

[49] Congress of the United States of America, 88th Congress, First Session, S. 984 (February 3, 1965).

More limited proposals have been made for establishing ombudsmen for specific areas of government activities in the United States. Senators E. V. Long and W. Magnuson, for instance, introduced a bill to establish tax ombudsmen in each of the 10 Internal Revenue Districts. These ombudsmen would represent taxpayers who ". . . are harrassed, annoyed, threatened and often may pay hundreds of dollars to a lawyer, not only to protect their constitutional rights but also to explain the vast complexities in our tax laws." [50] Similarly, several proposals have been made to establish an ombudsman in the health field.

In the United Kingdom, the Labor Party's Green Paper on National Health Service reorganization [51] recommended that a National Health Service ombudsman act as a channel for complaints from patients, an area that had been deliberately excluded from the Parliamentary Commissioner's sphere of action [52] when that office was established in 1967.[53] This recommendation disappeared in the Conservative consultative paper on National Health Service reorganization,[54] to reappear later, however, as an official policy when Sir Keith Joseph, Secretary of State of Social Services in the United Kingdom, proposed the appointment of commissioners to deal with complaints concerning the administrators of the National Health Service. This evolved into the subsequent establishment of three separate commissioners, one for England, one for Wales, and one for Scotland.[55]

It should be pointed out that in the United States most of the offices proposed, as well as those already operating under the name of ombudsman, particularly in city governments, have very little resemblance to the Swedish institution of the ombudsman. For the most part, they are information and complaint offices, without authority independent from the civil service administration, and as part of the normal structure of government, they are similar to the complaints department of a business enterprise.

In the light of the Swedish experience, the current debate in the United States over whether or not to create an ombudsman office in health or some other government sector seems to be focused incorrectly. In the United States, in theory, every administrative agency

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[50] "'Ombudsman', Citizen's Friend Comes to the U.S.," *National Observer.*

[51] Department of Health and Social Security (United Kingdom), *The Future Structure of the National Health Service.*

[52] In Northern Ireland, however, the general ombudsman, created in 1969, was empowered to investigate complaints related to the administration of the National Health Service.

[53] *British Medical Journal,* "Scotland's White Paper."

[54] Department of Health and Social Security (United Kingdom), *National Health Service Reorganization.*

[55] *Journal of the American Medical Association,* "International Comments."

that makes decisions concerning the rights of the individual, including agencies in health, social security, and welfare benefits, has an appeals system. Therefore, the topic for debate should be how to make the existing appeals apparatus more accessible to the average citizen. Only against this, is it useful to posit the creation of a new office with "new visibility," independent of the civil services administration, but accountable to Congress, that could channel, receive, and redress " . . . the possible transgressions of authority and abuse of power.[56] Of course, this alternative, to be accomplished in the proposed form of establishing an ombudsman at each level of government (federal, state, and local), might require amendment of the constitution.

Section II

THE LOCAL LEVEL

Local government in Sweden, in general, has greater public responsibilities than in other European countries. This is especially true for Swedish health planning, since most personal health services in Sweden are provided by the local government (the county communes).

The earliest form of local government in Sweden goes back to the Middle Ages, when local matters were decided by meetings of citizens in the villages. In the 17th and 18th centuries, these local councils were eclipsed by the church parish (socken), that came to exercise considerable control over health, poor relief, and schools. Later, in 1863, the communes as they exist today made their first appearance. They were supposed to deal with nonreligious matters at the local level, leaving religious affairs to the parish. At that time it was realized that a commune was too small a demographic unit to sustain certain social services such as hospitals and medical care, so for these purposes the county commune (landsting) was created. Their boundaries were chosen to coincide with the boundaries of the provinces (län), which were the political divisions that the central state authorities had used in 1634 to divide up the country for national administrative purposes. The number of local communes (referred to as

[56] Congress of the United States of America, *Hearing Before the Senate Subcommittee on Administrative Practice and Procedure of the Committee on the Judiciary* (March 7, 1966), 17.

primary communes) created was about 2500, and the number of county communes (called secondary communes) was 25, the same as today. The provinces were headed by a Governor (Landshövding) appointed by the King for life and responsible for the administration of state government programs at the provincial level.[57]

By and large, the 1863 division into primary communes remained intact until 1952, although from the 1930's onward there was an awareness that communal duties had increased so much that many of the smaller communes were not strong enough financially to carry out their functions. A Royal Commission was established to make recommendations on the reorganization of the size and boundaries of the primary commune, and its recommendations were subsequently approved by Parliament in the Local Government Act of 1953.[58] Under its provisions, no commune should be smaller than 3000 inhabitants. This reduced, not without considerable local resentment, the number of communes to about 1000.

At the end of the 1950's, the demand for even larger communes of not less than 6000–7000 inhabitants resulted in the appointment of another Royal Commission. This new demand grew from a concern that the administrative responsibilities of the communes were becoming more costly and numerous, particularly with regard to the care of the aged, and also education, since the nine-year compulsory comprehensive school had been introduced in the middle 1950's. The recommendation of the Commission was to stimulate the communes to amalgamate into blocks (kommunblock), of a minimum of 8000 people. This proposal was enacted by Parliament in 1962, and today there are 900 communes and 64 blocks. The block is thus a voluntary arrangement set up by the primary communes to provide some social services that require larger populations than that of a single primary commune, e.g., school health services, care of the elderly, social welfare, and home-aid services.

The demand for consolidation has also occurred at the county commune level. In 1967, for instance, another Royal Commission[59] recommended reducing the number of county communes from 25 to 15. Thus, the history of local authority can be defined as a continuous redefinition of its population boundaries to determine the necessary sustaining population for the social services under its responsibility.

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[57] An informative history of the local authorities is recoded in the two Royal Commission reports on local authorities: Swedish Government Documents, *Den Statliga Länstörvaltningen* and *Ny Länsindelning*.

[58] This law serves as a constitution for local government.

[59] Swedish Government Documents, *Ny Länsindelning*.

THE PRIMARY COMMUNES

The activities of the primary communes can be grouped into two categories, i.e., partly autonomous or unregulated, and obligatory, national or regulated. The first category is the sphere of local self-government proper, the second represents for the most part the decentralized administration of policies determined centrally at the national level.

The unregulated activities are derived from the sections of the Commune Law under which the commune has the right to decide on those affairs compatible with the public interest and not conflicting with the responsibilities assigned to other levels of government.

The most important among the autonomous activities are local transportation (local road systems, buses, trains, and airfields), water supply and sewage, gas, and electricity, among others. These types of services are usually provided by independent enterprises owned by the communes. Some communes also operate enterprises for profit, competing with the private sector in such activities as forestry and saw milling. However, a commune may exploit only those assets that it already owns but cannot buy new or additional properties for profit.[60] It is significant that the decision of the local council of the commune can only be appealed by an inhabitant of the commune within three weeks of the decision in question.[61] Such appeals may be made to the Governor or even to the Supreme Administrative Court, and there the decision can be voided, but it cannot be altered or changed. What this means in practice is that although a decision of the local council may be unlawful, it stands unless and until a proper appeal has been made (within three weeks), and the decision has been voided. Naturally, the result of this procedure is that the communes are engaged in a wide variety of activities of dubious legality.[62]

The regulated or obligatory activities are the result of the decentralized administration of centrally determined policies. These activities are regulated by national statutes and regulations, and include primary compulsory education, hygiene and sanitation, the supervision of elections, social welfare, fire protection, child welfare, and building and planning. Figure 3 shows the commune administration and its different activities.

The communes have the right to levy income taxes and receive the revenue of a tax on real estate. The most important sources of com-

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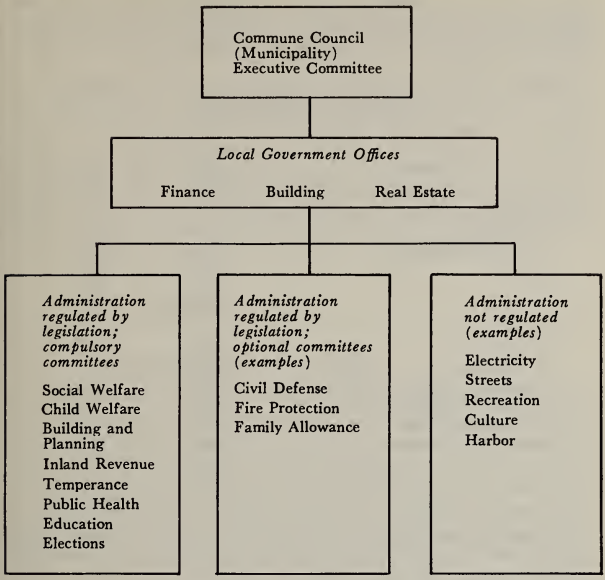
[60] The Swedish Institute, "Local Government in Sweden," 3.
[61] F. Kaijser, *Kommunallagarna, II.*
[62] J. B. Board, Jr., *The Government and Politics of Sweden*, 220.

FIGURE 3. THE SWEDISH PRIMARY COMMUNE ADMINISTRATION



Adapted from: E. Ödmann and G-B. Dahlberg, *Urbanization in Sweden; Means and Methods for Planning*, National Institute of Building and Urban Planning Research (Stockholm: Government Publishing House, 1970), 103.

munal revenue are the communal income tax, the local property tax, state categorical and block grants, and profits from local government enterprise. The income tax is the most important single source of revenue. It is proportional rather than progressive, with the rate being determined by the local council of the commune based on state assessments. The tax is collected by the Governor's Office of the province and then made available to the commune.

In terms of importance, the second source of revenue is the state grants, either categorical or block grants. Categorical grants are extended for the regulated or compulsory activities imposed on the commune by state legislation, such as education, hygiene and sanitation,

and others.[63] The block grants constitute an equalization subsidy, and are extended to poor communes with a particularly heavy tax burden, such as those in northern Sweden.[64] Table 4 shows the revenues and expenditures of the primary communes in 1967.

Table 4. REVENUES AND EXPENDITURES OF THE SWEDISH PRIMARY COMMUNES, 1967

Category	Million kronor	Percent
I. Revenues		
Taxes	9,458	45.9
Government subsidies	4,979	24.1
Other	6,187	31.0
Total	20,624	100.0
II. Expenditures		
Education	5,945	27.3
Welfare services	3,065	14.1
Health and medical services	1,509	6.9
Industrial activities	3,134	14.4
Highways and roads	2,449	11.2
Property management	2,437	11.2
Other	3,234	14.9
Total	21,773	100.0

Adapted from: The Swedish Institute, "Local Government in Sweden," *Fact Sheets on Sweden* (Stockholm: 1970), 3.

The Decision Makers: The Commune Council

The law making body in the primary communes is the local council (fullmäktige), which is the successor to the rural commune council (kommunalstämma) that existed until 1955 and functioned much like the New England town meetings in the United States.[65] The local council is elected every three years by proportional representation, and meets eight or ten times a year. Its chairman is elected by the councilmen from among themselves for a period of one year. The council is the legal authority responsible for the property of the commune: "It buys and sells real estate, determines tax rates, raises loans, and has the final word in the passage of the local budget.[66]

[63] This type of grant is particularly imortant in education.
[64] J. B. Board, Jr., *The Government and Politics of Sweden*, 221.
[65] Ibid., 224.
[66] Loc. cit.

The Planners and Administrators: The Commune Board

The executive and administrative body of the council is its board or executive committee, whose responsibilities include implementing council decisions, collecting communal income, administering communal property, and coordinating the work of the administrative committees. The board of five to seven members is elected by and from the council for a period of three years, with its chairman elected for the same period. The council has several committees that administer the different regulated and unregulated activities of the commune. The committee chairmen for regulated activities are sometimes appointed not by the council, as in the committees dealing with unregulated activities, but by the Governor, e.g., the elections and tax committees.

THE COUNTY COMMUNES

The Decision Makers: The County Council

The 25 county communes are responsible primarily for a number of compulsory tasks mandated by state law.[67] Among them are hospitals and medical care; vocational training and occupational medicine; [68] care of the mentally retarded; and intercommunal roads. Also, they are active in promoting the development of industry and tourism, and in some counties have established offices for regional physical planning to assist the primary communes in data collection as a means of supervising and coordinating planning at the communal level for larger areas. County communes do not, however, have any control or supervisory power over the activities performed by the primary communes within their boundaries.

The population of the county communes varies from 100,000 to 650,000, with the three cities of Stockholm, Göteborg, and Malmö as separate, independent communes. Actually, since 1971, the city of Stockholm has been integrated with the surrounding counties, creating a metropolitan county region. Every four years the county councils are elected according to a system of proportional representation. These councils consist of from 20 to 149 members, who are elected

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[67] Swedish Government Documents, *Förvaltning och Folkstyre*.

[68] These occupational medicine services are for the most part centers for physical therapy. They are not to be confused with the industrial medicine services that are run by the employers' associations and employ 300 physicians (företagsläkare). There is today a lively debate as to the future of these physicians, particularly on whether they should be employed by the employers' associations, by the trade unions, or by the county communes. The issue under discussion, of course, is with what group these physicians' loyalty should lie.

at the same time as the members of the primary commune councils and by the same franchise. They can also be elected to and serve simultaneously in Parliament. In 1965, for instance, 10% of the county council members were also Members of Parliament. The councils usually meet twice a year, with the main meeting in every council customarily in October and lasting approximately one week.

The Planners and Administrators: The County Board

The administrative and executive body of the council is the county board or executive committee, with a minimum of five members plus a chairman, all elected for three years by and from the county council. The county board is responsible for the administration of the county commune activities. Figure 4 diagrams a rather typical county government structure.

The Department of Planning has two divisions, one for long-term planning and in charge of developing the five-year economic projections (see Chapter 3), and another for research and statistics.

Of the county commune activities, the greatest amount of funds and activity goes to hospital and medical care. The county council has the power to levy taxes determined by the council according to a state assessment. These taxes are proportional rather than progressive. Table 5 shows the percentage breakdown of income and expenditure in the county councils.

FIGURE 4. STRUCTURE OF THE COUNTY GOVERNMENT IN SWEDEN

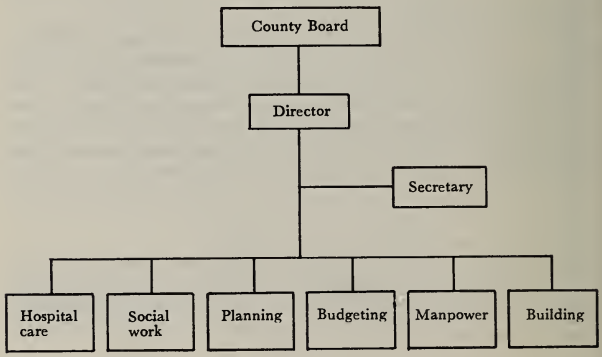

Table 5. PERCENTAGE ANALYSIS OF SWEDISH COUNTY COUNCIL REVENUE AND EXPENDITURES, 1971

Category	Percent
I. Revenues	
Interest	2
Fees	14
State contribution	19
Residual	11
Taxes	54
Total	100
II. Expenditures	
Education	6
Social work	3
Mentally retarded	7
Residual	6
Medical care	78
Total	100

Adapted from: R. Lind, "Public Health Services and the County Councils in Sweden" (Stockholm: Federation of County Councils), 13.

The county councils have a national federation, the Swedish Federation of County Councils[69] (Svenska Landstings Förbundet), that provides legal and administrative advice to member county communes, and represents the county authorities in the centralized salary negotiations with the unions of county communal employees. This federation has recently established, in collaboration with and under the combined sponsorship of the Ministry of Health and Social Affairs, a research institute in health planning, the National Institute for the Planning and Rationalization of Health and Social Welfare Services (SPRI). The SPRI undertakes research on health services and acts as consultant to the county councils, among other areas, in the preparation of the 5-year economic projections within the health sector.

ADMINISTRATIVE RELATIONSHIP BETWEEN NATIONAL AND LOCAL GOVERNMENT

The Provincial Government: The Governor's Office

During the 18th and 19th centuries, the King ruled as an absolute monarch. In each of the 25 provinces there was a Governor represent-

[69] This federation is also referred to as the Swedish Association of County Communes.

ing and appointed by the King, with primary responsibility for establishing order in the province and collecting the taxes. These taxes were then divided proportionally among the local governments of the communes. His secondary responsibility was to survey and transmit the local communes' moods and demands to the King. Worth underlining is that political democracy, in the sense of one man-one vote and universal suffrage, was not instituted in Sweden until 1918.

Today, the maintenance of public order and security, taxation, and the taking of censuses are still the responsibility of the Governor's Office (länsstyrelse). Also, that office is supposed to be an administrative court of appeals in which citizens can lodge complaints against communal decisions.

Appointed by the King in Council, the Governor has the same authority as the Director General of a National Board. The Governor and his staff relate to the Ministry of Physical Planning and Local Government as the other agencies relate to the Ministries. Governors continue to be appointed for life,[70] but recently there has been extensive discussion of reducing this appointment to four years. During the general reorganization of the national government in 1971, the Governor's Office was reorganized along the lines of a state agency. The Governors are now assisted by a 10-member lay board (the Governor's Board), in which five members are appointed by the communes.

Besides the functions mentioned above, the Governor and his staff (including, among others, public health officers responsible for hygiene and sanitation programs),[71] supervise and coordinate the central government programs administered at the local level by the communes. As mentioned before, the communes, either primary or secondary, do not have the financial base to pay for the activities, particularly social services, they are responsible for, requiring state subsidies in the form of grants-in-aid. The Governor's Office supervises and coordinates the different state grants-in-aid to the county council (which has the same boundaries as the province) and to the different primary communes within the province, comparable in some degree to the regional offices used by the federal departments in the United States. The differences between them, however, are that most of the central government activities in a province are coordinated under the jurisdiction of one office, while in the United States, each federal department administers its programs through separate regional offices. Recently, in an attempt to alter this situation in the United States, federal executive

[70] For life, in this context, means until retirement.

[71] Actually, although the public health officers work practically as members of the Governor's staff, they are in theory on loan from the National Board of Health.

boards have been created for 14 centers of concentration of federal regional offices.[72]

In Sweden, most of the grants-in-aid to the local governments, such as subsidies for health and welfare programs, hospital construction, water supply, sewage disposal, and road construction, go through the Governor's Office. It is the responsibility of this Office to supervise and regulate the application of national standards (prepared by the agencies) of the programs administered in the day-to-day operations of the primary and secondary communes. The reader will recall that these programs comprise the regulated or compulsory activities of the communes.

Not all the state government activities at the provincial level, however, are administered by the Governor's Office. Some national boards, including, among others, the National Board of Health, have regional offices at the provincial level which are responsible for some activities independently of the Governor's Office. These include the mails, insurance, waterways, and some aspects of public health, such as public health laboratories. These regional offices are run by regional boards accountable and responsible to the national agencies instead of the Governor's Office. To alleviate the lack of coordination among the different state programs resulting from this structure, the Governor or his representatives are sometimes appointed to chair the regional boards of the national agencies. Nonetheless, the lack of coordination persists, and there is growing concern that, as a result of this expansion of the activities of the central government and the increasing number of grants-in-aid to local governments or communes, this structure may require further changes and possibly integration of the independent regional boards of the national agencies with the Governor's Office.

In 1971, to solve this problem of coordination at least partially, the Governor's Office was reorganized into three main departments: planning, general administration and political matters, and fiscal affairs. Planning matters related to residential construction, location of schools and hospitals, and rationalization of agriculture, among others, have been referred and delegated from the regional offices of the central agencies to the Governor's Office, giving it greater authority for regional planning and development. At the same time, it is hoped that the commune authorities, through their representatives on the newly appointed Governor's Board, will be able to participate directly in decisions by the central government's provincial bodies. The aim of this reorganization is to provide integration between provincial ad-

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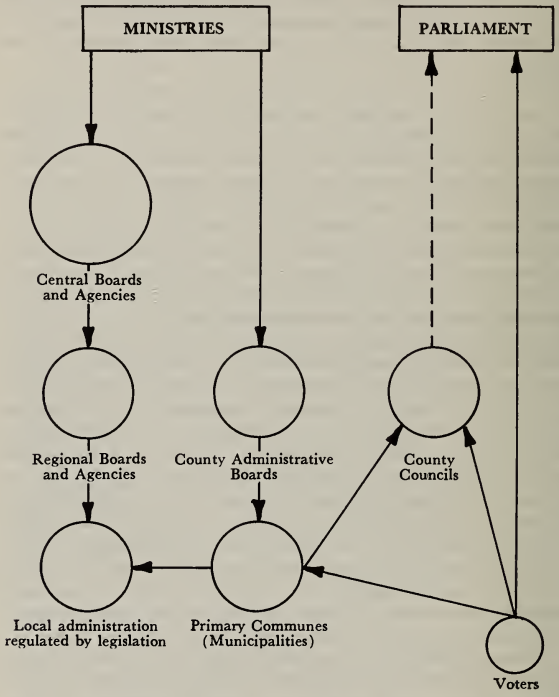
[72] A. H. Rosenthal, *Regional Coordination: The Role of Federal Executive Boards.*

ministration and development.[73] Figure 5 represents the present structure of and interrelationships in the Swedish government.

Worth underlining is the present debate in both Sweden and the United States over the degree of centralization required by some

FIGURE 5. THE SWEDISH PUBLIC ADMINISTRATION SYSTEM



Adapted from: E. Ödmann and G-B. Dahlberg, *Urbanization in Sweden: Means and Methods for Planning*, National Institute of Building and Urban Planning Research (Stockholm: Government Publishing House, 1970), 99.

[73] P. Vinde, *Swedish Government Administration: An Introduction*, 49.

government functions, particularly in the social sectors. The county councils and the provinces in Sweden have an average population of 300,000. But increasingly there are problems, such as air pollution created by counties and provinces, that cannot be solved at that level and require the combined efforts of the counties and the provinces. However, there is no intermediate level of government between the small authorities of the county communes and the communes and the provinces on the one hand and the central government on the other. To partially solve this situation, voluntary collaboration has been established among counties to set up regional committees of several counties to solve common problems. The regional committees for the provision of tertiary care health services illustrate this kind of collaboration. Another example, also from the health sector, is the collaboration of two counties and a municipality in the south of Sweden to establish a master plan of health services for the region. The weaknesses and strengths of this particular voluntary arrangement are discussed in subsequent chapters.

Chapter 2

SWEDISH SOCIAL SECURITY AND THE HEALTH SERVICES

INTRODUCTION

It is not commonly known that Sweden's social security system is a relatively recent development, although the idea of a general public insurance program dates to 1913, when the first national pension plan went into effect. While at that time the benefits were too restricted to be significant, the strength of the program was its reliance on the principle of universality.[1] Three years later, the beginnings of an industrial accident insurance program emerged, and in 1931 the government began to provide grants-in-aid to the regional and local voluntary health insurance programs which covered about 70% of the population. It was this intervention by the government in the field of health funding that opened the door for the establishment, in the subsequent decade, of a national health insurance system.

In terms of the present debate in the United States concerning the advisability of national health insurance, it may be of interest to list the principal arguments given, before and after 1931, by the different social groups that advocated compulsory national health insurance in Sweden. One argument was that while 70% of the population was covered by the voluntary system, that system failed to cover those sectors of the population most in need of the insurance, the "poor risks."[2] Also, because of the increased costs of providing care and the growing scope of health insurance benefits, the latter mainly as a result of the growing power of the labor movement, premiums had increased to such a degree that it became impossible to deduct them from the wages

[1] F. Fleisher, *The New Sweden: The Challenge of a Disciplined Economy*, 199.
[2] J. B. Board, Jr., *The Government and Politics of Sweden*, 233.

of low-income earners.[3] Another concern of the labor movement was that incomes and living standards were inadequately protected during periods of unemployment resulting from illness.[4]

After debates similar to the discussions going on in the United States today, Parliament took the initial step of instituting national health insurance in 1947, although enabling legislation was not passed until 1953 and implementation was postponed until 1955, seven years after the British National Health Service had been established. In 1959, Sweden enacted a general supplementary pension program, and since 1963, the National Health Insurance Act,[5] the Basic Pension Act, and the National Supplementary Pension Act have been combined into a single National Insurance Act.

Much attention and praise has been given to the Swedish social security system. Sweden, however, is not a welfare heaven. As Rosenthal indicates, there has been some misunderstanding about this in the United States and other countries,[6] but Swedish authorities are quite frank on this point.[7] Ernst Michanek, the former Undersecretary of the Department of Social Affairs, who was highly instrumental in designing the recent expansion of the social security program, has written: "The preceding . . . may have given the impression that Sweden has solved the problems of old age. This is not true.[8] Again, this author writes: "We have not yet reached our goals. On the contrary, there are many things that cause us discontent—but a discontent that is constructive in nature." [9]

Actually, an examination of the social services programs in the United States and Sweden reveals a striking, and to some observers,[10] surprising similarity in terms of both the scope and the objectives of their social security programs. Table 6 compares, as an example, the benefits of the pension systems in the United States and Sweden, which constitute the largest part of the social security in both countries.

The health insurance programs of the two countries, however, are

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[3] The Swedish Institute, "Social Insurance in Sweden," 1.

[4] J. B. Board, Jr., *The Government and Politics of Sweden*, 233.

[5] The National Health Insurance Act is also often referred to as the National Sickness Insurance Act.

[6] Actually, the lay press has repeated and sustained, rather uncritically, most of the myths concerning the Swedish welfare state. Such an exposition of one aspect of the social services in Sweden, old age care, is Simone de Beauvoir's article on old age care in different countries in the *New York Times Sunday Magazine*, May 7, 1972. Also, great emphasis has been given in the popular press to the now discredited argument of the tendency of the Swedish welfare system to dull the will to work. For an example of this type of article, see S. Sontag, "A Letter from Sweden."

[7] A. H. Rosenthal, *The Social Programs of Sweden*, 136.

[8] E. Michanek, *Old Age in Sweden*, 36.

[9] E. Michanek, *For and Against the Swedish Welfare State: Swedish Experiences*, 44.

[10] A. H. Rosenthal, loc. cit.

Table 6. COMPARISON OF BENEFITS OF PENSION SYSTEMS IN SWEDEN AND THE UNITED STATES

Sweden	United States
Coverage	
Universal. No citizenship requirement. Includes government employees who have own retirement system coordinated with the Supplementary Pension system. Includes self-employed.	Almost universal. Covers 90 percent of all gainfully employed No citizenship requirement. Excludes federal government employees who have own retirement system. State and local employes included by agreement. Includes self-employed.
Eligibility	
Based on 15 highest earning years of a 20-year earning period.	Based on year of birth; coverage must equal one quarter of coverage under social security for each year after 1950, or age 22 if later, to year of death or attainment of retirement age (62 for both men and women starting with 1975) with a minimum of 6 quarters and a maximum of 40.
Provisions	
Reduced amounts permitted by 1/20 for each year not covered in installation of program. Pension credits require minimum of $800	Most benefits based on years after 1950, or age 22 if later, less 5 years, to year of death or year of attaining retirement age.
Benefits	
Retirement, disability, and survivor's benefits. Ranges from $6.40 per month plus Basic Pension of $98.30 to $312 a month plus Basic Pension of $98.30 when plan is in full operation.	Retirement, disability, and survivor's benefits. Ranges from retirement benefit at 65 of $84.50 to maximum of $404.50 with maximum family payment of $707.90 (maximums not payable until future years).
Cost of living adjustment	
Annually adjusted to cost-of-living index.	Annual Adjustment to cost of living possible starting with 1975.
Wife's benefit	
Benefit provided by Basic Pension. No special provision under Supplementary Pension.	Additional amount of 1/2 husband's benefit provided for wife 65 years of age or older. Reduced benefit at age 62.
Widow's benefit	
Widow receives 40 percent of benefit if no children. Basic Pension provides additional payment of 90 percent of the base amount.	Widow under 65 will receive 3/4 of benefit amount if she has child under 18 or disabled in her care; disabled widow 50-60 can receive 50–71 1/2 percent of benefit amount depending on

Table 6. COMPARISON OF BENEFITS OF PENSION SYSTEMS IN SWEDEN AND THE UNITED STATES (Continued)

Sweden	United States	Sweden	United States
Coverage		**Benefits**	
to maximum of $7050 per year.	Lower eligibility requirements for older population during installation program. Benefit credits accrue for minimum of $50 per calendar quarter to maximum of $6600 per year effective in 1966. Earnings covered to maximum $10,800 in 1973; $12,000 in 1974.		age; widow 60–65 or older can receive 71 1/2–100 percent of benefit amount depending on age.
		Children's benefit	
		Covers children under 19. One survivor receives 40 percent of pension, 2 survivors 50 percent, and 3 survivors 60 percent.	Covers unmarried children under 18, 18–22 if full-time students; disabled children over 18 if disabled before 22. Each surviving child gets 3/4 of wage earner's benefit amount subject to maximum; upon retirement, child, like wife, receives 1/2 of benefit subject to maximum.
Restrictions			
No earnings restrictions for full eligibility at age 67.	Retirement test requires substantial retirement from gainful employment up to age 72.	**Burial benefits**	
		None.	Three times monthly benefit with maximum of $255.
Age			
For full benefits, 67 years; for reduced benefits, 63; for increased benefits, after 67.	For full benefits, 65 years, (reduced benefits at age 62) with application of retirement test.		

Adapted from: A. H. Rosenthal, *The Social Programs of Sweden* (Minneapolis: University of Minnesota Press, 1969), 139–141.

strikingly dissimilar. In the following paragraphs, the Swedish health insurance program is described, appraised, and compared with some aspects of the current and proposed federal health insurance programs in the United States.

In the second part of the section, a recent major reform in the system of payment for physicians is described, as well as the administration of social insurance and the funding of social benefits.

Section I

SOCIAL SECURITY

NATIONAL HEALTH INSURANCE

The Swedish national health insurance plan is a financing mechanism for medical and hospital care and for the provision of cash benefits related to income in case of sickness. It is aimed at pooling all risks to offset medical expenditures and the decrease in living standards otherwise resulting from disease, disability, or unemployment for medical reasons.

The major characteristics of the national health program are as follows:

> . . . (1) it is universal in coverage; (2) it is compulsory; (3) it provides comprehensive benefits; (4) it operates on a cash basis with a deductible feature; (5) it is contributory; and (6) it is income-related in that it has graduated premiums and benefits.[11]

While the Swedish insurance scheme does deal with the payment for services and cash benefits, it has nothing to do with the ownership or organization of health services. The owners of facilities and contractors of services are the local authorities—the county communes—which pay, partly from their tax revenue, for the majority of hospital and medical expenditures in Sweden (70% of the total health care cost). Complementing the local tax funds are the national health insurance contributions paid by gainfully employed persons, employers, and the State, which pay for a small part of the hospital expenditures and for most ambulatory care. Actually, national health insurance pays for only 7% of total health care costs.

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[11] A. H. Rosenthal, *The Social Programs of Sweden*, 37.

Benefits

Sickness benefits are comprised of (1) medical benefits, (2) cash sickness benefits, and (3) maternity benefits.

Medical Benefits

Ambulatory Care. Medical benefits include allowances for medical expenses, including coverage of various payments made in connection with treatment by a physician, whether public or private, by a dental surgeon on some occasions, or by hospitals. When the visit is to a physician working in the outpatient department of a public hospital or to a district physician (physician employed by the local authorities), the patient pays 7 kronor to the institution,[12] which is owned, administered, and partly financed by the local authorities, and the local insurance fund pays 31 kronor. The institution thus receives 38 kronor (7 + 31) of the total cost of 70 kronor for an ambulatory visit (the other 32 kronor (70 − 38) are paid from local tax funds). The fee also covers x-ray examinations, x-ray or radioisotope treatment, and laboratory tests and examinations. The physician is paid on a salary basis.

If the patient visits a physician privately, the physician may charge any fee he wishes, noting the fees and acknowledging receipt on a prescribed form. The patient takes that receipt to the local insurance fund, which will reimburse the patient for 75% of the insurance fee schedule for the particular item of care. The same procedure applies to fees for x-ray examinations and x-ray and radioisotope treatments performed on a private basis. The patient thus pays 25% of the fee schedule. Private physicians are not required to charge patients according to insurance tariff rates and very rarely do. Actually, in large cities, the difference is likely to be considerable, so that the insurance refund may cover as little as 25% of the actual fee charged by the physician.

The health insurance fee schedule is established by the National Social Insurance Board, after consultation with the Swedish Medical Association, according to three different categories: group I includes single consultations with examination and treatment; group II covers consultations including treatment with minor surgery; and group III covers consultations involving special treatment, major surgery, gynecology, ophthalmology, ear, nose, and throat, and psychiatry. The rates are slightly higher in Stockholm than in the rest of the country

[12] The patient pays 15 kronor for a home visit and 2 kronor for a telephone consultation. The local insurance fund pays 31 kronor to the local authority for the former and 4 kronor for the latter. As of 1973 the patient payment to the institution will be 12 kronor and the institution will receive 48 kronor from the local insurance fund.

(e.g., although the fee schedules for group I are the same (10 kronor) in Stockholm as in the rest of Sweden, for group II, they are 25 and 20 kronor, and for group III, 60 and 45 kronor, respectively).

The extent of medical benefits in Medicare, the comparable program in the United States based on an insurance approach (but only covering people sixty-five and older, and certain disabled people under 65), is that for those who agree to pay the voluntary payment of $6.30/month (part B), the insurance pays, after the first $60 of expenses paid by the patient, 80% of the reasonable charge for all covered medical expenditures per year, including medical and surgical services by a physician and any treatment and tests required.

Hospital and Institutional Care. The insured person in Sweden who is in need of hospitalization receives hospital care, including maintenance, treatment, nursing, medicines, and all auxiliary services, free of charge. The local insurance fund pays the hospital 10 kronor/day of hospitalization,[13] which represents approximately 7% of the daily costs of hospitalization. The other 80 kronor are covered from the tax revenues of the county communes.[14] Normally the insured person is hospitalized in the local hospital administered by his county commune. If some specialized treatment not available at that hospital is required, the insurance fund pays for hospitalization in another hospital, at the lowest rate for which such care can be provided. Similar types of payment apply for nursing home and convalescent care. For home care services provided by the primary communes or municipalities, the patient pays according to his income.

Again, Medicare, the program in the United States that most resembles the Swedish insurance program, pays, after an initial deduction of $72, the costs of 60 days of hospitalization per renewable benefit period illness, and most of the costs, except for $18/day paid by the patient, for another 30 days. In addition, there is a non-replenishable 60-day lifetime reserve, for which the patient pays $36 per day. The lifetime limit for mental hospitalization is 190 days. The extent of benefit coverage for hospitalization is similar to Sweden except that physicians' fees are not covered under the basic (part A) scheme in Medicare and that certain miscellaneous items are not covered, such as the first three pints of blood in each illness. Physicians' fees are covered under the supplementary medical benefits scheme (part B). Skilled nursing home care after hospitalization is covered by Medicare

[13] These 10 kronor/day are deducted from the patient cash benefits.

[14] Before 1970, if the patient wanted to have a private room, he could pay 35 kronor, and for a semiprivate, 20 kronor. If privacy was required medically, the patient did not pay the additional fee. This policy was abolished as part of the equalization program described later.

during the first 20 days, and all but $9 daily for the next 80 days. For home care benefits, part A pays for up to 100 visits during a year, if the care follows hospital or nursing home care. Another 100 visits per year are provided under Part B.

Travel expenses above 6 kronor to and from the nearest public physician's office and from the hospital are paid by the local insurance fund for the least expensive transport available. In Stockholm the patient's share is slightly higher, but, on the other hand, the patient can travel to any point in town. When the patient visits a private physician, the insurance pays the travel cost equivalent to visiting the nearest district doctor (after the first 6 kronor). When the patient has been referred to a hospital or to another physician by his own physician, or in the case of emergency treatment, the travel to and from the point of care is paid. Also, traveling expenses may be paid for persons accompanying the patient because of age or condition. The United States Medicare program makes no provision for transportation costs.

A general comparison of the extent of coverage for hospital and institutional care in Sweden and the United States, restricted to the elderly population in the latter country, thus shows that federal health insurance is more limited here than in Sweden, with more deductibles and insurance features.

Dental Care. Serious surgical interventions, plastic interventions and excisions, and x-ray examinations are paid if they are provided in special public clinics, a university clinic, or a public hospital. Preventive and normal care are not paid, except for pregnant women for a period of up to 270 days after delivery. In this case, the woman pays 25% of the fee schedule, and the local insurance fund pays the other 75%. Again, private dentists rarely restrict themselves to those fees.

Other Medical Care. Occupational, physical, and rehabilitative therapies, when performed outside of the hospital, mostly in private practice, are covered up to 75% by the insurance fee schedule. Expenses for care in public convalescent homes are also refunded.

Drugs and Pharmaceutical Supplies. The patient is required to pay the full price of drugs if the cost is less than 5 kronor. If the cost is more than that, but less than 25 kronor, he pays half that price, and if it is more than 25 kronor, he only pays 15 kronor. Life-saving drugs, such as insulin for diabetics, are free of charge.

Cash Sickness Benefits

The main principle behind this type of insurance is to protect the citizen's standard of living against loss because of disability related to

sickness. In the Swedish system, this insurance includes basic and supplementary cash sickness benefits. Basic benefits cover housewives and other insured persons with an annual income from gainful occupation of at least 1800 kronor. The "housewife" category covers every woman under 67 with an annual income of less than 1800 kronor who is married and lives with her husband, or a child under 16, or with a man with whom she has had a child. Supplementary cash sickness benefits cover all persons with an annual income from gainful occupation of at least 2600 kronor. In addition to the basic and supplementary cash benefits, employees can increase their insurance voluntarily provided it does not exceed the total benefit of 15 kronor/day.

The total sickness benefits (basic and supplementary) for the various income groups are given in Table 7. According to the scale of cash benefits, when totally disabled because of sickness, the patient receives roughly 80% (up to 39,000 kronor/year) of the income he

Table 7. TOTAL CASH SICKNESS BENEFITS UNDER SWEDISH NATIONAL HEALTH INSURANCE

Sickness benefit class	Annual income (kronor)		Daily sickness benefit (kronor)
	Not less than	Less than	
1*	....	....	6
2	1,800	2,600	6
3	2,600	3,400	7
4	3,400	4,200	8
5	4,200	5,000	9
6	5,000	5,800	10
7	5,800	6,800	12
8	6,800	8,400	14
9	8,400	10,200	16
10	10,200	12,000	19
11	12,000	14,000	22
12	14,000	16,000	25
13	16,000	18,000	28
14	18,000	21,000	31
15	21,000	24,000	34
16	24,000	27,000	37
17	27,000	30,000	40
18	30,000	33,000	43
19	33,000	36,000	46
20	36,000	39,000	49
21	39,000	....	52

*Housewives

Adapted from: S. Wengström, "National Sickness Insurance in Sweden" (Stockholm: Försäkringskasseförbundet, 1970), 10.

would be earning if well. If working capacity is reduced by one-half or more, then half the amount of cash sickness benefits is payable. If the reduction in working capacity is less than one-half, no cash benefits are paid.

Besides the basic and supplementary cash benefits, a supplement is payable for children under 16, with 1 kronor/day for 1 or 2 children, 2 kronor/day for 3 or 4 children, and 3 kronor/day for more than 4 children. If only half of the sickness benefits is payable, half the children's supplement is paid. If the child is hospitalized, then his cash sickness benefits are reduced by 5 kronor.

Maternity Benefits

The costs of care related to pregnancy and childbirth are reimbursed to the same extent as those for illness. In addition, a cash maternity benefit of 1080 kronor is given to each insured woman giving birth to a child. If more than one child is born in the same delivery, 540 kronor are paid for each additional child. Also, women who are insured for supplementary cash sickness benefits and who have been insured for a period of at least 270 days prior to confinement are entitled to supplementary cash sickness benefits in connection with confinement.

In the light of this extensive system of benefits in Sweden, which is more comprehensive and generous than the United States equivalent, it is interesting to see how the principal individual provider of services, the physician, is paid and how insurance benefits and services are administered and funded.

PAYMENT OF PHYSICIANS

The 7 Kronor Reform

Prior to January 1, 1970, when a patient visited a physician employed by the local authority, either in a hospital outpatient department or in the office of a district physician, he was obliged to pay the full cost of the fee charged by the public physician, based on the fee schedule set by the Social Insurance Board in collaboration with the Swedish Medical Association. For a normal visit the fee would be 10 kronor. The patient would be reimbursed by the local insurance fund for 75% of the fee, or 7 kronor, and the patient would pay 25%, or 3 kronor.[15]

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[15] For a discussion of the previous system of payment in Sweden and other countries, see W. A. Glaser, *Paying the Doctor.*

If the patient needed laboratory tests, he would pay for these by a separate bill and later would be reimbursed for 75% of the fee schedule by the local insurance fund.

In theory, there was a similar arrangement when a patient visited a private physician. In practice, however, only very rarely would the latter follow the insurance schedule for his fees or laboratory tests, and the patient would pay considerably more than 25% of the fees and charges involved.

In 1970, a change in health insurance was introduced, aimed at (1) simplifying the administration of the payment for ambulatory care; (2) making it easier for the patient to obtain ambulatory care; (3) eliminating all economic transactions between the patient and the physician; and (4) equalizing the different salaries within the medical profession. This last aim was partly motivated by the desire of the Social Insurance Board and the National Federation of County Councils to simplify the overall administration of the payment of physicians, and partly by the ideological commitment of the new leadership within the Social Democratic government—the Olof Palme government—to the concept of income equalization.

Under this reform, the patient, when visiting a public physician, pays the institution, that is, the county commune, the previous charge of 7 kronor (the amount estimated by the Social Insurance Board as the cost to the patient for the average visit in the public sector before the 1970 reform). The local insurance fund pays the county commune 32 kronor.[16] These payments, incidentally, cover only part of the actual cost of the ambulatory visits, which is estimated to be 70 kronor. The remainder is paid by the county commune from its tax revenues. For the payment of 7 kronor, the patient is entitled to receive all care and tests required for treatment, including referrals and further visits to other physicians and hospitals, without extra charge, provided that the referrals are motivated by the same condition and disease. Preventive care, however, such as checkups, screenings, and distribution of contraceptives, is not covered, and the patient has to pay a set fee. These costs are not reimbursed by the insurance fund.

When the patient visits a private physician he pays 25% of the fee schedule, and the local insurance fund pays the other 75%, although the fee schedule is usually less than the actual fee charged by the private physician. The patient has to pay a set fee for any tests and special treatment, much as before 1970.

As a result of these changes, the administration of payments and re-

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[16] J. Sahlin, "Enhetstaxa och Läkarvardag," 59.

imbursements for ambulatory care in the public sector has been simplified greatly both for the patient and the insurance fund and local authorities. The patient merely pays the 7 kronor and is not involved in the reimbursement process. Thus, a fixed amount is paid to the county by the patient and the insurance fund, regardless of the type of care. This administrative simplification also was aimed at making ambulatory care more accessible, by reducing the transactions involved, and, in some cases, making the care less expensive (for those patients needing many tests) than before the reform. In a pattern not dissimilar to voluntary insurance in the United States, the Swedish system before the reform was favoring hospitalization over ambulatory care, hospital care being free and at least portions of ambulatory care restricted in coverage and in some instances quite expensive (as in the case of category III visits with greater numbers of tests). Actually, one of the aims of the 7-kronor reform seems to have been to emphasize ambulatory care as a way of saving hospitalization. No evaluative studies have been performed as yet to confirm the validity of this assumption and thus the wisdom of the new policy.[17]

Physician Salaries

Parallel to this change in the method of payment by the patient, there was a change in the method of payment of physicians in the public sector. Before the reform, physicians working in the public sector, whether in hospitals or as district physicians, had been paid a basic salary according to seniority and specialty, ranging from $6000/year for residents in hospitals and district physicians to $12,000–$15,000 for the chief physician in a hospital. This salary was supplemented by the fees paid directly by the ambulatory patient (who was reimbursed for 75% of the fee by the local insurance fund), according to the insurance fee schedule. This additional source of income considerably increased the salary of the public physician, depending, of course, on the number of ambulatory patients seen, and many residents had a total income of around $15,000 (ranging from $12,000 to $30,000) and some heads of hospital services had incomes of $40,000 or more.[18] Under the 1970 reform, all physicians employed by the county communes are now on total salary and paid according to hours of work, not according to number of patients. They are obliged to work a fixed number of hours per week, which now ranges from 45–50 hours, but

[17] B. N. Shenkin, "Politics and Medical Care in Sweden: The Seven Crowns Reform."
[18] L. Werko, "Swedish Medical Care in Transition."

is calculated to decrease to 40–42 hours by the late 1970's. The percentage of this time dedicated to patient care, research, or teaching is practically at the physician's discretion.

Physician salaries were standardized by specialty, place, and region of work, so that the only differences were according to seniority. Table 8 shows some of the salary levels. They were estimated, on the basis of the averaging of salaries in each category of physician at different levels of seniority, by the National Federation of County Councils and the Social Insurance Board with the consultation but not the participation of the Swedish Medical Association.

Table 8. SALARY LEVELS OF SWEDISH PHYSICIANS IN PUBLIC SERVICE

Position	Salary		Overtime pay per month for weekly hour* (kronor)
	Kronor	Approximate dollar equiv.	
Department Head	115,692	22,000	230
District Officer	101,844	19,000	195
District Head	98,052	18,500	170
Junior Physician	83,292	16,000	150

*The Department Head gets 230 kronor a month if he works an extra hour each week.
Adapted from: "Sveriges Läkarförbund" (Stockholm: February, 1970), 4.

The majority of young physicians supported the reform, which for them meant improved salary and working conditions, with fixed daily working hours. The more senior physicians opposed the reform, partly because they felt the reform deprofessionalized medical practice and converted it into "common work,"[19] and partly because it affected their incomes. To alleviate this situation to some degree, local insurance funds and county communes seem to tolerate private practice by some senior physicians who are in public employment.[20]

For physicians working full time in private practice, the system of payment is practically the same as before 1970. Their patients pay the fees requested, fees that are usually more than the insurance rates. The patient is reimbursed 75% of the fee schedule. Worth underlining

[19] L. Werko, "Swedish Medical Care in Transition."

[20] Actually, it can be postulated that the lack of active resistance by the Swedish Medical Association to that reform was mainly due to the different degrees of response by the medical profession. While the overall income of the tertiary care specialists was likely to be limited as a result of the process of equalization, the income of secondary and mainly primary care specialists not only did not decline but in some case improved. (B. N. Shenkin, op. cit.)

is that there has been a tendency for these private physicians, mostly working in solo practice, to develop an interest in group practice. Group practice in the Swedish context is similar to the medical foundation in the United States. A peculiarity of the Swedish arrangement, however, is that patients pay the foundation a fee for each visit, while the physicians in this practice are paid on a salary basis, rated not according to the number of patients, but according to the number of visits. At the moment, these foundations are discussing with the Social Insurance Board the possibility of being paid the 31 kronor that the local insurance fund pays the county commune for each ambulatory visit. If this were to become the case, senior physicians dissatisfied with the 1970 reform would very likely move from the public to the private sector, preferring to become members of a foundation rather than being employees of the county communes. Some counties with an insufficient supply of physicians would favor providing the facilities for the work of a group of physicians as a means of making the area appealing to them. If the Social Insurance Board does not agree to pay the 31 kronor to the physicians in group practices, it is highly unlikely that the system will expand beyond its present limited size.

In speaking of the reform popularly referred to as the "7 Swedish kronor," a note should be added about the principle of equalization within the professions, which has been stated as one of the objectives of the reform. To an outside observer, however, it seems that administrative considerations have more explanatory value than political ones. Actually, if political considerations had been primary, one cannot help questioning, why equalize the medical profession and no others? A plausible explanation is that medicine was the profession with higher incomes and that there was a desire in the new Swedish central administration to bring medical incomes to a level comparable to those of other professions. Whatever the reason, however, the government has not made this aspect of its policy reform very explicit.

ADMINISTRATION OF SOCIAL INSURANCE

Social insurance funds are administered at the county level in 26 fund units—one for each county, except for the counties combined in one fund, and the three cities of Stockholm, Göteborg, and Lund. The funds administer the national pension insurance and the industrial injury insurance, as well as the health insurance. Heading each local insurance fund is a managing committee of seven members, one member appointed by the government, one by the Social In-

surance Board, one by the county administration, and the other members by the county council. These nonpaid members have a staff whose director, the senior social insurance officer, is not appointed by them but by the National Social Insurance Board.

Local insurance funds are registered under the National Social Insurance Board, which is under the Ministry of Health and Social Affairs. The Board acts as a coordinating agency and central information center, supervising the local insurance funds, which are actually administered in a highly decentralized way. It charges employers for their contribution to social insurance and administers those parts of the pensions and injury insurance not provided for by the local funds. The Social Insurance Board has an office of planning and another for research which provide the necessary information on which to base policy. Indeed, most of the information required to change the system of patient and physician payments in 1970 was obtained by the office of the Board.

Above the Social Insurance Board is the Division of Social Insurance in the Ministry of Health and Social Affairs, whose functions have been detailed earlier. Among them are the drafting of legislation requested by the Cabinet, for example, for the 1970 reform. The procedure followed for the passage of that bill is fairly representative of the process by which policy and its execution takes place, and how Ministers, Cabinet, Parliament, and the agencies relate to each other. The prepared bill, after being approved by the Cabinet, was passed to Parliament, to be discussed and worked out by the Parliamentary Standing Committee on Social Insurance, before it was considered by Parliament in session. After the bill was approved by Parliament, the Division of Social Insurance within the Ministry then proceeded to establish the relevant guidelines for policy execution and implementation of the law by the Social Insurance Board and the local insurance funds (see Chapter 1 for more detailed discussion of this process). Once a measure in this field is implemented, any affected citizen may appeal to the local fund, to the Social Insurance Board, and to the Insurance Court.

The Funding of Social Benefits and Its Implications for a Welfare State

In 1967, the national health insurance was financed by about 39% from employees, 48% from employers contributions, and 13% by appropriations from the revenues of the national government.[21] The

[21] K. Mauritzon, "The Swedish National Health Insurance," 59.

rate of contributions by the self-employed is higher because they have to pay both as employer and employee.

The insured persons' contributions comprise the contribution for medical benefits and for cash sickness benefits. The medical benefit contribution is calculated by the Social Insurance Board after consultation with the local fund, and it is estimated according to the marginal aggregate required to cover the expenses not covered by the other sources of funds in each county. On the average, it is 2% of the total taxable income.

The employers pay 3.1% of the wage bill for their employees. Of this percentage, the major portion, 75%, goes to cash sickness benefits, 20% to medical benefits, and 5% to maternity benefits.[22] The state subsidizes health insurance to the extent of 55% of all compulsory benefits—medical, cash sickness benefits, children's supplements, and cash maternity benefits; and 20% of the voluntary sickness benefits. It has been calculated that the health insurance contributions for individuals and their wives, at average income levels, are about 2.1% of their annual incomes, and the employers' contribution for them is an additional 1.5% of that income.[23]

The total health care bill in Sweden is met by contributions of approximately 1% from patients' fees, 7% from health insurance, 13% from the state government, 70% from county taxes, and the remaining 8% from miscellaneous sources.

It is noteworthy that health insurance covers only 7% of the whole medical care bill. Considering that over 50% of this health insurance is paid by the central government, one must conclude that the employer-employee contribution pays for less than 3.5% of the total health care bill. Therefore, it is misleading to refer to the funding of the Swedish health services system as an example of national health insurance. Actually, most of the revenues are from the county councils (proportional taxation) and from the state (progressive taxation), and thus the mechanism of funding, although not its source (central government in the United Kingdom and local in Sweden), bears a closer resemblance to the British National Health Service than to the continental European systems, in which employer-employee contributions cover large parts of the health care costs. This fact is generally overlooked by most authors discussing the Swedish system.

A last note, relevant to the current debate on the nature of the welfare state, is to what degree do the social services and, for our

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[22] Personal communication, National Social Insurance Board, 1971.

[23] C. G. Uhr, *Sweden's Social Security System: An Appraisal of Its Economic Impact in the Postwar Period*, 84.

purposes, the health services in particular, redistribute income within society? It has been the accepted belief among social planners that the provision of social services with concomitant measures of taxation was equalizing the distribution of income among social classes in most of the western industrialized societies. Indeed, the objective of income equalization, presumed to exist in the modern welfare state, was supposed to be attainable by these measures.

Only very recently, however, have studies such as those of Titmuss in the United Kingdom [24] and Kolko in the United States [25] shown that taxation and the provision of social services have not had the expected equalizing effect. In fact, they have indicated that, contrary to the conventional wisdom, social inequality among classes has not only *not diminished* but has even increased in the last two decades. Their studies demonstrate that the patterns of taxation, as well as the programs for providing social services, including health services, have failed to effect the social equalization for which they were designed. A similar conclusion was reached in Sweden in the 1970 Long-Term Survey,[26] which indicated that no meaningful reduction of income disparity among social classes has occurred in the period from 1950–1970 among the adult population of Sweden.

Within this general picture, then, a pertinent question is how the funding and consumption of health services can contribute to the process of income equalization referred to above. Actually, in the current debate on national health insurance in the United States, very little attention, if any, is being paid to judging the merits of the various proposals by the criteria of their effect on minimizing income inequalities among social classes. All these proposals accept the mechanism of insurance with proportional taxation as the means of paying for medical care. But as one acute observer of medical care legislation in the United States has indicated:

> Consider the medicare proposal from the vantage point of justice, and in the context of the larger provisions of the social security schema to which it is attached. The principle of payment is the most significant violation of social justice, combining as it does the characteristics of both proportionate and regressive taxation. By imposing the same percentage of taxation on all incomes within its scope the measure enacts a thoroughly conservative principle of proportionate contribution. The underlying judgment that supports proportionate payment is an acceptance of the current distribution of wealth, for if one taxes in constant proportion, the relations

[24] R. Titmuss, *Income Distribution and Social Change.*

[25] G. Kolko, *Wealth and Power in America: An Analysis of Social Class and Income Distribution.*

[26] Ministry of Finance (Sweden), *The Swedish Economy 1971–1975 and the General Outlook up to 1990: The 1970 Long-Term Survey.*

> of wealth are maintained as they are . . . . And the difficulty cannot fail to grow in the face of the realization that the system is also regressive in that it taxes a larger relative portion of the income of those who are less able to afford it. The injustice of the system is then completed by distributing welfare in proportion to contribution, and in inverse relation to need.[27]

Proportional taxation—taxing the same percentage of income independently of the level of income--is a tool of income stabilization, not income redistribution. In Sweden, fully 73% of the funds for payment of health services is collected by proportional taxation, 70% from county commune funds and 3% from employer-employee contributions. On the basis of these figures, it would seem that the health services do not have a redistributive effect on income in Sweden today. Moreover, considering that the upper classes consume health services more than the lower classes,[28] one could well argue that the lower classes are actually subsidizing the care of the upper classes, and that the funding, at least that 73% of health services funds, is regressive in practice. Thus, if the aim of the funding of social benefits was to equalize income, it must be concluded that the present Swedish health system has failed to achieve this aim. [29]

Section II

SWEDISH HEALTH SERVICES

A functional analysis of the resources operating within the health services system in Sweden shows three main sectors—general medicine (ambulatory or general medical care), hospital and institutional medicine, and public health services. This tripartite structure exists in many western industrialized nations and in the developing countries as well.

Figure 6 indicates the relationship between the problems and the current responsibilities of the three main sectors of the health services. Question marks indicate those functions where there is an unclear area

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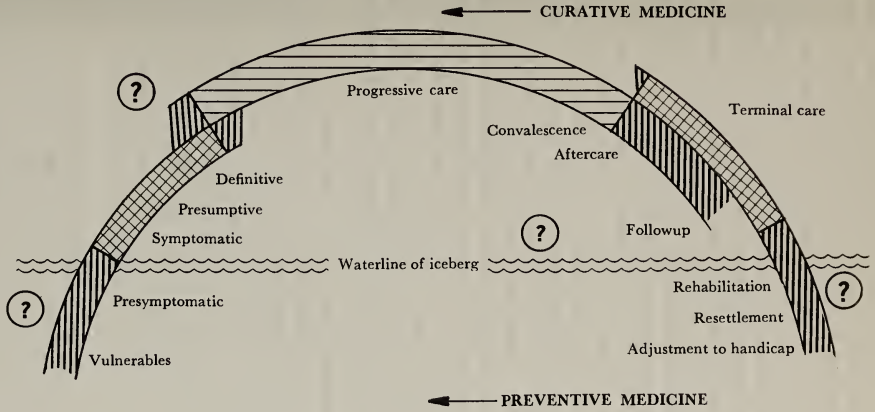
[27] R. Lichtman, "The Political Economy of Medical Care," 267–268.

[28] R. Andersen, B. Smedby, and O. W. Anderson, *Medical Care Use in Sweden and the United States.*

[29] For a fuller discussion of the failure of the social programs (including health services) to redistribute income in today's Sweden, see A. Myrdal, *Towards Equality: The Alva Myrdal Report to the Swedish Social Democratic Party.*

FIGURE 6. THE SPECTRUM OF MEDICAL CARE



Adapted from: R. F. L. Logan, *Problems and Progress in Medical Care* (London: Nuffield Provincial Hospital Trust, 1964), 21.

of responsibility. The curved bar (both light and dark portions) of Figure 6 illustrates the imaginary curve of the evolution of disease. The curve begins on the left with a healthy but vulnerable population in whom a morbid condition might develop when exposed to certain circumstances. Once the disease appears, the first stage is usually silent and represents presymptomatic morbidity that, if allowed to develop, might flourish into full morbidity. This disease might then be translated into demand, depending on the patient's perception of it, response to it, and the availability and accessibility of health resources. Above the waterline of the iceberg (the wavy horizontal line) is known morbidity or demand, with the patient under the direct responsibility of the various sectors of the health services system. After the patient is discharged from the system (on the right side of the disease curve), there remain his physical, emotional, vocational, and social rehabilitation and his readjustment to an able life.

Within the evolution of disease, as illustrated by the arc in Figure 6, who is responsible for the patient's care in Sweden today? On the left side of the demand curve, where need is translated into demand in the portion of the iceberg above the waterline, most of the ambulatory care is provided in the offices of the district medical officers employed by the county commune, in hospital outpatient departments also administered by the county communes, or in the offices of the private physicians. Thus, primary or ambulatory care is provided by the physicians, and with the exception of private practice, administered by the county councils. Hospital and all other institutional care is both provided and administered by the county councils.

It is significant that in Sweden, as in the United Kingdom and generally in Europe, a general separation exists between ambulatory and inpatient care, and a corresponding separation of physicians. Under this arrangement, when a patient is discharged from the hospital and shifts to the convalescent stage (the right side of the demand curve in Figure 6), he is then under the responsibility of the physician in charge of ambulatory care. This change of responsibility, depending on the patient's horizontal or vertical position, leads to a discontinuity of care that may be supposed to be not conducive to the provision of integrated care.

Curative medicine, then, has been the aspect of medical and hospital services that has dealt with this demand or exposed portion of the iceberg. However, when the full size of the health problem is discerned, curative medicine becomes but a small part of that problem. Figure 6 also shows the unknown areas of the health problem (the submerged portion of the iceberg) where responsibility for care is sometimes vague and poorly delineated. On the left side of the

submerged part of the iceberg in Figure 6 is the vulnerable population, for instance, for which care or primary prevention, as listed by Morris,[30] is provided through legislation, environmental engineering, education policy, the mass media, new social attitudes to leisure, and the presentation of alternative life styles. This care has traditionally been the domain, in a limited sense, of the public health sector. Frequently, another function of this sector is secondary prevention, including the much debated screening programs[31] for early detection of beginning and mild cases. Also evolving as part of the screening program is the detection of unknown morbidity. However, the clear assignment of responsibility for discovering this portion of morbidity, or secondary prevention, as well as for primary prevention, is lacking in the health services in Sweden, as well as in most of the industrialized countries.

For example, in Sweden, part of the *primary prevention*,[32] such as immunization, is done on a contractual basis for the municipalities by the district officer (physician working in the public sector), and the district nurse (who has functions similar to the American public health nurse), both working independently although under the same mandate of the county communes. On the other hand, school health services, with their own nurses, are run by the primary communes or municipalities. Maternal and child care services (mödra och barnavardscenhaler) are available in special centers provided and equipped by the primary communes and staffed, on a part-time basis, with the district doctors and nurses, and with their own nurses. The operating expenses of these latter services are paid by the county communes.

In addition, part of the protection of the vulnerable population is in the sphere of occupational medicine services (arbetarskydds tyrelsen), which are administered and supervised, not by the primary communes nor by the county councils, but by the industrial inspectors[33] (yrkesinspectionen) of the Governor's Office in the provincial government. The health supervision of environmental services, sewage, water supply, and pollution is the responsibility of the public health officers (länsläkare) also working in the Governor's Office.

The responsibility for screening, or *secondary prevention*, is generally distributed among the districts, the primary communes, and,

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[30] J. N. Morris, "Tomorrow's Community Physician."

[31] T. McKeown et al. *Screening in Medical Care*.

[32] The terms primary, secondary and tertiary prevention are used according to J. N. Morris' definitions in *Uses of Epidemiology*.

[33] These occupational officers are rarely physicians. Most of them are chemists and/or engineers.

for some conditions, the provincial government. Hospitals, particularly teaching hospitals, also may be involved in screening programs, but more as part of their research than as normal procedure.

On the right side of the disease curve in Figure 6 is what is described as the great challenge in today's medicine, *tertiary prevention* or rehabilitation of the patient—not only physical, but emotional and social as well. It includes the care needed, for example, by the stroke patient, the alcoholic, or the drug addict to rehabilitate him to a fitting life. And it is particularly on this side of the spectrum of care that medical care requires a close working relationship with the social services. Nevertheless, at present, the responsibility for this care in Sweden is diffused among social welfare services, public health services, hospitals, and so forth, and no single agency holds a clear mandate for assuming this function.

Physical rehabilitation, for instance, may be provided in general or specialized hospitals, or in special clinics, while social rehabilitation is performed primarily by the social medicine doctor (socialläkare), whose work is similar to that of a senior social worker in the United States. Most of these social medicine doctors are psychiatrists and their existence as a separate specialty has been criticized as solidifying the somewhat artificial distinction between the social and the somatic dimensions of disease. They are employed by the county councils. In addition, there are the social medical workers (kurators) who work in institutions and are responsible to the respective directors of the institutions, and the social workers (socialassistent) who are employed by the primary communes.

In summary, in Sweden, as this and other authors have found in the United Kingdom and the United States,[34] the distribution of responsibilities among various sectors of the health services system under different administrations, with separate administrations in charge of curative and preventive services, reflects historical and sectional pressures more than logic and rational allocation of resources. Indeed, in Sweden, with few exceptions, the health supervision of the environmental services [35] is mostly the responsibility of the provincial government. Of the personal health services, the bulk of curative services (dealing with the known part of the clinical iceberg, or demand) are the responsibility of different branches of the county communes, while the majority of preventive services and some curative services

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[34] See: J. N. Morris, "Tomorrow's Community Physician"; R. F. L. Logan, *Problems and Progress in Medical Care;* T. McKeown, *Medicine in Modern Society;* V. Navarro, "Redefining the Health Problem and Implications for Planning Personal Health Services."

[35] Those services that affect the health of the individual through changes in the man-made as well as the natural environment.

are the responsibility of the primary communes or municipalities. This division of responsibilities, under different administrations, seriously impairs the provision of integrated services. In this regard, the Swedish experience has some relevance to the proposed restructuring of the administration of the British National Health Service, as reflected in the last consultative paper on the reorganization of the British health services system.[36] The guiding idea in this paper is the integration of the three sectors—public health, general practice, and hospital services—into one administrative authority. For example, it is suggested that, in the proposed restructuring, more coordination and integration would be possible if general practitioners were placed under the same administration as hospitals. In Sweden, both are under the county communes, and in spite of this, there exists a gap between ambulatory care and hospital care similar to the gap present in the United Kingdom.

Thus, it would seem that placing both sectors—general practice and hospitals—under the same administration may be a necessary but not a sufficient condition to reach the desired level of integration.[37] Concerned with the coordination of care between both sectors, some health planners in Sweden are encouraging physicians to do hospital work for the equivalent of one day per week. Also, it is felt that the integration of both sectors under one administration has to occur at the lowest level of administration possible, the medical block, as was suggested in the regional health plan for Stockholm, which will be described in Chapter 5.

Similarly, the restructuring of health services in the United Kingdom proposes the delegation of paramedical personnel, such as public health nurses, from the local authorities to the general practice services. In Sweden, the public health nurses and the district nurses have been under the same administration and even, in some communes like Dalby, under the same roof (in the health center) as the general practitioners and district officers, and, nevertheless, they all work rather independently of each other.

In view of this experience, it again would seem that integration under one administration, although necessary, is not sufficient, and that other administrative arrangements, such as the establishment of

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[36] Department of Health and Social Security (United Kingdom), *National Health Service Reorganization*.

[37] It is worth noting that in the proposed restructuring of health services in the United Kingdom, the general practitioners will be administered by the same administrative authority—the area health authority—as the hospitals. It is hoped that by placing both general practice and hospitals under the same administration, their integration will be facilitated. The Swedish experience, however, would seem to indicate that more than the running of both services by the same administration will be necessary to achieve that integration.

health teams, may be required to achieve adequate integration of the provision of care. In this respect, it should be emphasized that the various primary care health workers in Sweden do not work as health teams. Also, similar to the situation in the United Kingdom, social medical work is run by one authority—the municipality or primary commune—and medical care by another, which in the United Kingdom is the proposed area health authority, and in Sweden the county commune.

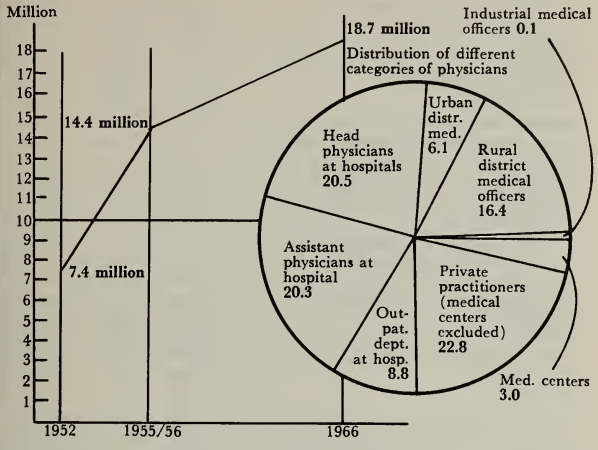
HEALTH MANPOWER

In Sweden there were approximately 10,500 working physicians in 1970, equivalent to 9000 full-time physicians. This number corresponded to a ratio of 1 physician per 800 inhabitants. Of the full-time physicians, 7200 were working the public sector, mostly (about 6000) as hospital doctors, and 1200 were working in ambulatory care, mostly as district doctors. Of the latter, 1000 were in general practice and 200 were specialists. Actually, the Manpower Division of the National Board of Health estimates a need for 1200 more physicians, calculated on the basis of unfilled positions. With an annual output of 600 physicians from the six medical schools, the production of physicians increased by 75% during the period from 1950–1965, a lesser rate, however, than that for other health workers. Nurses and midwives increased by 83%, physiotherapists by 112%, and occupational therapists by 740%. Table 9 shows the distribution of the different types of health manpower in 1965 and the rates of growth from 1950–1965.

On the other side of the production-consumption equation, during the period from 1950–1965 the consumption of ambulatory care increased by 250%. Half of the ambulatory visits today are made to hospitals, one fourth to private practitioners, and another fourth to the district medical officers.[38] The pattern of consumption of ambulatory care is shown in Figure 7, which shows both the increase in the total number of consultations in ambulatory care and the setting in which they took place. It is worth underlining that Sweden has a low rate of consultations for ambulatory care—less than three visits per inhabitant per year, as opposed to 4.5 and 5.5 in the United States and the United Kingdom.[39]

[38] G. Wennström, "Training of Health Workers in the Swedish Medical Care System."
[39] G. Wennström, "Training of Health Workers in the Swedish Medical Care System."

FIGURE 7. INCREASE IN CONSULTATIONS IN OUTPATIENT CARE AND PATTERNS OF DISTRIBUTION BY PHYSICIAN CATEGORIES IN SWEDEN



Adapted from: G. Wennström, "Training of Health Workers in the Swedish Medical Care System," *Annals of the New York Academy of Sciences*, 166:985–1001 (1969), 987.

The Public Sector: District Officers

The district officers are the physicians working on a salary basis outside the hospitals under the administrative control of the county council. The responsibilities of district officers are similar to those of the British general practitioners, i.e., to provide medical care to patients within the district (medical division of the county commune) who want to pay no more than the 7 kronor charge (before 1970, the stipulated insurance rate). Since 1970, as discussed in Section I, patients pay the standard fee of 7 kronor, not to the district officer, but to the county commune. In addition to medical care, the district officer handles the provision of some preventive services, such as the school health program, on a contractual basis with the municipalities or primary communes. Their salaries are the same for all parts of Sweden, and communes try to attract physicians to their counties by offering housing, offices, equipment, and paramedical and auxiliary personnel—amenities that vary from county to county.

Most of these district officers work in solo practice, with no per-

Table 9. INCREASE IN THE NUMBER OF HEALTH WORKERS IN SWEDEN, 1950–1965

Personnel category	Number		Changes in percent
	1950	1965	
Physicians	4,890	8,520	+ 75
Nurses and midwives	14,160	25,956	+ 83
Physiotherapists	1,090	2,310	+112
Occupational therapists	50	420	+740
Social welfare officers at general hospitals	105	360	+245
Nursing aides and others at general hospitals	21,520	35,790	+ 66
Nursing aides and others at mental hospitals	7,890	12,870	+ 63
Nursing personnel at institutions for the mentally handicapped and epileptics	2,220	5,430	+145
Hospital administration personnel	1,350	2,730	+102
Catering personnel	13,530	16,520	+ 22
Dentists	3,430	6,080	+ 77
Dental technicians	1,500	2,300	+ 53
Dental nurses	3,400	6,800	+100
Pharmacists	900	790	− 12
Pharmacy dispensers	960	1,750	+ 82
Pharmacy apprentices and technicians	4,200	6,420	+ 53
Total	81,195	134,040	+ 65

Adapted from: G. Wennström, "Training of Health Workers in the Swedish Medical Care System," *Annals of the New York Academy of Sciences*, 166:985–1001 (1969), 988.

sonnel attached to them. The district nurses, also employed by the county council, work practically independently, much as in the United Kingdom and the United States. District nurses are not attached to and do not work with the district physicians, except in the rural areas, where they have some clinical responsibilities under the supervision of the district physicians. In this case, there is a resemblance with the American medical assistants or nursing practitioners. Social workers, employed by the primary commune or municipality, and other paramedical personnel, such as physical or occupational therapists employed by the county councils, are likewise not attached to the district physician.

Their working conditions, in solo practice and in most cases without direct paramedical or auxiliary assistance and without hospital privileges, have led to a concern among health planners about the effect of this isolation of practice on the quality of care. New policies for

care at this level are now being explored on a pilot basis. There is a pilot project, for example, to create health centers in which several district officers would work together—three or four for a population of 10,000—side by side with paramedical and auxiliary personnel. Also, in one health center, Dalby, used as an academic setting for the teaching of ambulatory care to medical students, social services personnel have been attached to the center to provide integrated care to the community.[40]

The district officers, as well as all other clinicians in the Swedish system, are medically accountable to the National Board of Health. The Board must approve the creation of all new district officer positions, and every appointment to such positions. Officially, the National Board actually appoints the district officers, but administratively, they depend on the director of health services of the county commune. Only recently, in some cities like Stockholm, to achieve closer coordination and integration between the district officers and the hospitals, have the district officers been made administratively dependent on the medical director of the district. The medical director is also in charge of the administration of the hospitals within his district.

The Private Sector: Private Practice

There are approximately 1200 private practitioners in Sweden, 600 of them in Stockholm. The other half are primarily located in the two other large cities, Göteborg and Lund-Malmö.[41] The future of private practice, after the 7-kronor reform, will depend on whether private practitioners are willing to work in group practices and/or whether the local insurance funds would be prepared to pay to those group practices (arranged like the American medical foundations) the 31 kronor they pay the local authorities for the services of the public physician. Unless these two conditions are met, as was discussed earlier in this chapter, it is unlikely that private practice will expand in Sweden. Voluntary health insurance, like BUPA in the United Kingdom or the Blues in the United States, is nonexistent.

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[40] It was this observer's impression, however, that in spite of working under the same administration and even under the same roof, the different professionals and paraprofessionals were working not as a health team but much more independently.

[41] See discussion in Section I on the system of payment to the private physicians and their income.

HOSPITAL CARE

Sweden has a very high bed count relative to its population—a ratio of 16 beds per 1000. It is estimated that by the middle of the 1970's, the ratio will have increased to 18 beds per 1000. The corresponding figures for the United States and the United Kingdom are 8 and 10 beds per 1000 inhabitants. The percentage of the population admitted to a general hospital during one year in Sweden is 8.5%, compared with 10% for the United States and 6.6% for the United Kingdom.[42] The average length of stay in short-term hospitals was, in 1967, 11.5 days in Sweden, 8.3 in the United States, and 11.9 in the United Kingdom, and the hospital days per 1000 people were 4310 in Sweden, 2550 in the United States, and 2940 in the United Kingdom. Table 10 shows the number of hospital beds in Sweden in 1965, and their increase during the period from 1950–1965. The greatest increase occurred in beds for long-term ahd mentally handicapped patients.

The hospital has the highest priority within the Swedish health services system.[43] The high rate of hospital construction is certainly impressive to an outsider, particularly since the occupancy rate has been declining steadily, from 84.9% in 1950 to 73% in 1968.[44] Eighty percent of the operating expenses and 50% of the capital expenditures of the county council are for hospitalization. A number of hypotheses can be advanced to explain this investment in the hospital sector. Among them, the political visibility of the hospital and related institutions is certainly a temptation for local authorities whose main expenditures are hospital and medical care and who have taxing power under their control. Another explanation may be the great influence that the medical profession, primarily that part based in the academic institutions and teaching hospitals, has had in determining priorities within the health sector. As we will see later, the influence of these professional groups, by way of advisory councils and committees, has been considerable, and local authorities have only very rarely been opposed to the hospital priorities of the academic medical profession. The increased cost of hospital care, however, and public complaints about the very high level of taxation, have resulted in a search for alternatives to hospital care, and in a corresponding slow-

[42] In 1967, admissions to hospitals for the mentally ill per 1000 people were 4.2 in the United States, 10.0 in Sweden, and 3.5 in the United Kingdom.

[43] Sweden expended, in 1965, 47% of the national health expenditures in hospitals and 6% in nursing homes. The United States expended, in the same year, 34% and 3% respectively, and the United Kingdom, 39% and 4% respectively. (O. W. Anderson, *Health Care: Can There Be Equity? The United States, Sweden, and England*).

[44] National Board of Health (Sweden), *RUPRO 69: Summary in English*, 3.

Table 10. INCREASE IN THE NUMBER OF HOSPITAL BEDS IN SWEDEN, 1950–1965

Branch of care	Number of beds, 1965	Percent increase
Somatic diseases (long-term diseases excluded, but psychiatric wards in general hospitals included)	52,000	6
Long-term diseases	23,200	152
Mental diseases (psychiatric wards in general hospitals excluded)	34,400	22
Mentally handicapped	15,800	27
Total	125,400	26

Adapted from: G. Wennström, "Training of Health Workers in the Swedish Medical Care System," *Annals of the New York Academy of Sciences*, 166:985–1001 (1969), 986.

down in hospital construction concurrent with increased investment in ambulatory care.

Structure of the Hospital Sector

Each hospital is directed by a medical director (styresman), who is a clinician with half-time administrative responsibility, and the superintendent, who is a full-time administrator for the hotel and ancillary services of the hospital. The clinics are under the medical director, with a head for each clinic, and under these are the departments, each headed by a chief. In addition, under the medical director, and at the same level as the head of a clinic, is the matron in charge of the administration of nursing services.

The medical directors, the heads of the clinics and the chiefs of departments are administratively responsible to the managing medical director of the county commune, and each position is under the administrative supervision of the immediately superior one. For example, department budgets have to be approved by the heads of the clinics; clinic budgets by the hospital medical director; and hospital budgets by the managing medical director of the county commune.

Medically, however, the medical director of the hospital, the heads of the clinics, and the chiefs of the departments are responsible not to the county council but, exclusively, to the National Board of Health for matters such as quality of care, treatment and prescribing policies, and other medical tasks. This dual accountability is not without problems, since there is no clear distinction between medical and administrative matters. In practice, this dual accountability and the

lack of precise distinction between the two areas of accountability affords a great deal of independence to the leading medical staff of the hospitals.

All other physicians working in the hospitals are medically and administratively accountable and responsible to the chiefs, heads, and medical directors of the hospitals.

REGIONALIZATION OF HEALTH SERVICES

There is a large bibliography on regionalization of health services in Sweden, particularly since the Royal Commission on Regionalization of Health Services, in 1962, published its report dividing the country into six regions and encouraging the regionalization of health services according to a defined model of health care distribution. (See Chapter 5 for a more detailed description and analysis of regional planning as advanced in that report.)

What, however, is meant by regionalization? Indeed, the term has been used very broadly and should be defined before the Swedish health services can be analyzed and appraised according to their proximity or distance from this concept.[45] Regionalization is the distribution and allocation of resources according to types of care on three levels: primary or ambulatory services; secondary or specialty care; and tertiary or superspecialty services. These three levels are related and linked by a movement of patients from the periphery, the point of entry or primary care, to the center, and a movement of staff from the center to the periphery. Figure 8 shows the model of regionalization according to the Royal Commissions's recommendations. The three levels of care are discussed in the following.

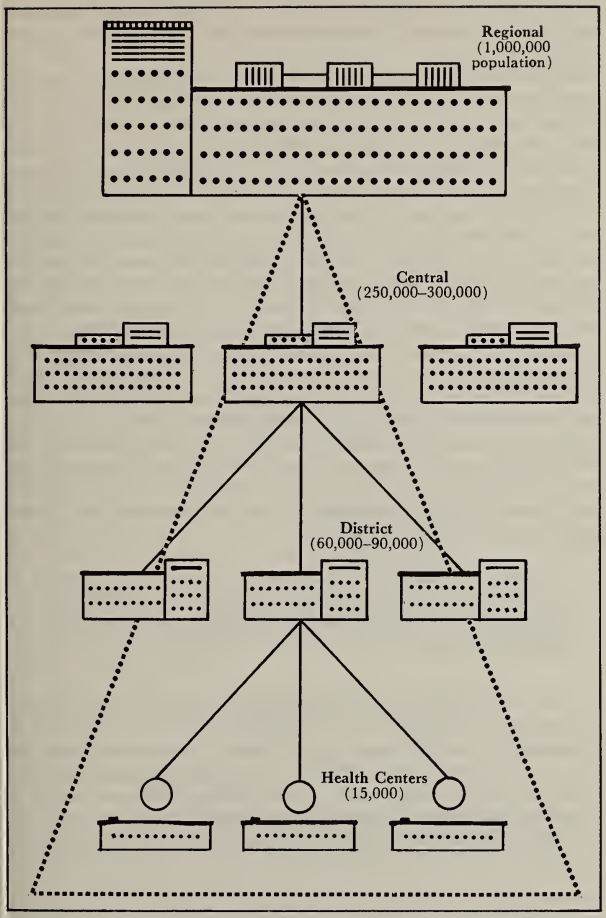
Tertiary Care Services: The Regional Committees

The county communes, with an average size of 250,000 people, did not offer sufficiently large catchment areas for those specialties, such as cardiosurgery and plastic surgery, that are usually referred to as tertiary care specialties.[46] Indeed, a county commune has come to be considered too small for the provision of even such social services as

[45] For a detailed description of a suggested regional model, see V. Navarro, "The City and the Region; A Critical Relationship in the Distribution of Health Resources."

[46] According to the Royal Commission on Regionalization, these tertiary services are neurosurgery, plastic surgery, thoracic surgery, radiotherapy, neurology, and dermatology (divided between regional hospitals and the largest county hospitals), rheumatology, urology, child surgery, and special cardiology. See A. Engel, *Regionsjukvarden*.

FIGURE 8. REGIONALIZATION OF SWEDISH HEALTH SERVICES



Adapted from: A. Engel, "Planning and Spontaneity in the Development of the Swedish Health System," 1968 Michael M. Davis Lecture (Chicago: University of Chicago, Center for Health Administration Studies, 1968), 9.

secondary schools and vocational schools and for the provision of tertiary health care services. Awareness of this fact explains the recommendations of the Royal Commission, which are not yet implemented, on reorganization of the county councils to reduce their number from 25 to 15.

To provide tertiary care services, the Royal Commission on Regionalization made a recommendation similar to that made a decade later in the United Kingdom, in 1970, in the second Green Paper on the restructuring of the National Health Service, i.e., that voluntary arrangements among several county councils (districts in the United Kingdom) for the provision of tertiary services should be encouraged. The Royal Commission advised the creation of a committee for each region that would plan and administer the intercounty arrangements required for the provision of these superspecialties so as to avoid the duplication of these services among the county communes. A decade after the establishment of those regional committees, evidence points to the fact that collaboration and avoidance of duplication among county communes in each region is highly irregular. Indeed, although some counties did follow the pattern advised by the Royal Commission, others did not. As we see in discussing the Skane case in Chapter 5, voluntary collaboration presupposes that the various institutions coming together on a voluntary basis might achieve common objectives through mutual reinforcement. When the American and the Swedish experiences are analyzed closely, however, the feasibility of these voluntary arrangements appear questionable. Indeed, the commitment to a common objective is highly correlated

> . . . with each institution benefiting from such an arrangement. And it is quite doubtful that each institution would perceive the curtailment of its autonomy that regionalization would require as being beneficial. Furthermore, it is doubtful that the different institutions would have such a concert of interests.[47]

The institutional objectives are greatly influenced by the medical professionals working in those institutions, and the delegation of responsibility and curtailment of privileges that regionalization implies are resisted by these groups. Frequently this resistance is reinforced by the political bodies in the county communes, jealous of their prerogatives and reluctant to delegate to other hospitals and counties the provision of tertiary services. In this respect, the benefits

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[47] V. Navarro, "The City and the Region: A Critical Relationship in the Distribution of Health Resources," 883.

of cost savings that such delegation would permit have not been seen as sufficient by the county communes to warrant relinquishing those services to other counties.

It is significant that the National Board of Health has a measure of indirect control over the regionalization of tertiary care services, because the Board must approve the creation of any new staff positions at the professional level in a county hospital or institution. The perception of this observer, however, is that the National Board has used this control more seldom than often. More recently, the increased costs of hospital care have stimulated the National Board to start exercising its control as a means of encouraging regionalization. There are, however, loopholes in its ability to exercise this control. It cannot close down staff positions that already exist. Thus, it does not have the restraining powers that may be required to avoid the present duplication of services. Also, teaching and other hospitals can bypass control by the Board by obtaining funds and resources for their highly specialized services from other sources, such as research grants, outside the National Board's control, presenting it with a *fait accompli.*

The present situation of a voluntaristic approach to regional planning for the tertiary care facilities, in which the county communes raise their own revenues for medical and hospital care and in which the National Board of Health has only a loose and indirect control over the allocation of resources, seems to have handicapped the implementation of the regional model of health services at the tertiary care level. This situation would also tend to explain the demand on the part of certain health planners for the creation of an intermediate level of authority at the regional level—either a regional office of a state authority or a regional authority elected by the county communes—between the county commune and the state levels, with the power and responsibility to plan for the regionalization of these services.

Secondary Care Services: Their Administrative Structure

The services to be provided at the secondary level, according to the Royal Commission, are:

> . . . internal medicine, general surgery, pediatrics, gynecology and obstetrics, ENT, ophthalmology, neurology, dermatology, orthopedics, minor psychiatry, child psychiatry, rehabilitation clinic, long-term disease and dental clinics.[48]

[48] A. Engel, *Regionsjukvarden.*

These services are very similar to those advocated in Scotland by a joint working party appointed by the Secretary of State of Scotland and the Scottish Home and Health Department.[49]

Secondary care services are supposed to be provided by the county commune hospitals and institutions, which are owned and administered by the county councils. As described earlier, the administrative management of these institutions—the medical director and the superintendent—is under the responsibility of the managing medical director, who is a civil servant appointed for life (until his retirement) by the medical services committee of the county council, the top political authority of the county commune. Where the county communes or the cities are very large, they are divided into several medical districts. The highest political authority for health services in each district is a medical district committee of appointed members from the county council and from the municipalities within the county.[50] Each district has a medical director, and his staff, who is administratively responsible to the managing medical director of the county council, and politically responsible to the medical district committee.

Under the district medical officer are the medical directors of the health institutions. It should be noted that each institution is responsible for a population within a geographically defined area. In large cities like Stockholm, each citizen is provided with a booklet (Landstingskatalogen) in which according to his address he can find the location and telephone number of the different types of services he may require. Visits to facilities other than those indicated are, although possible, discouraged.

Figure 9 shows the distribution of authority and accountability at the county and district level. Political accountability refers to the accountability among political bodies and relates to policy matters, such as overall distribution of resources between districts and municipalities. The implementation of these policies generates administrative responsibility and a process of administrative accountability among the administrative bodies.

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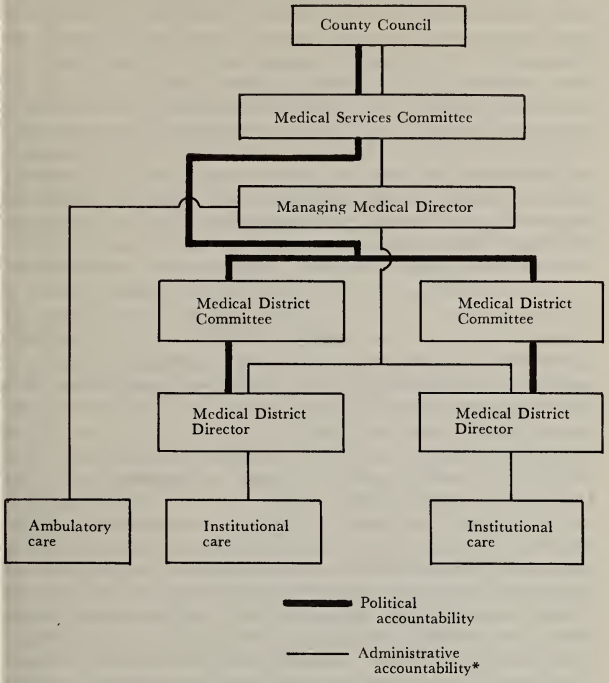
[49] Scottish Home and Health Department, *Doctors in an Integrated Health Service.*

[50] The boundaries of the medical district are different from the boundaries of the municipalities, which complicates the coordination between medical and hospital care services (run by the county and the districts' communes) and the social and environmental services (run by the municipalities). Actually, this situation is similar to that in the United Kingdom where local authorities in charge of social and environmental services have different boundaries from the hospital and general practice regions, a situation that has led to a poor coordination among medical and social services. The restructuring of these boundaries to make them coincide is one of the features of the new proposals for reorganization of the health services. Similarly, in the United States, a demand has been made for the boundaries and catchment areas of the different federal health programs to coincide. See A. Levin, *The Satisficers.*

FIGURE 9. THE ADMINISTRATIVE STRUCTURE AT THE COUNTY AND DISTRICT LEVELS IN SWEDEN



*See text for clarification.

Worth underlining is that at present ambulatory care provided by district physicians and district nurses is administratively dependent on the managing medical director of the county commune, and not on the district medical director. Only recently, and to insure better coordination and integration of ambulatory and hospital care, has the city of Stockholm delegated the administrative responsibility for the district physicians and district nurses to the district medical director.

To what degree do the services follow a system of regionalization, according to the Royal Commission's model? It is the impression of this observer that on the whole, the model of regional-

ization for the secondary care services has not been fully implemented, and that the different institutions at the county commune level, with some exceptions in the rural county communes, are not regionalized. This is so notwithstanding the fact that the ownership and administration of the various hospitals are in the same hands—the county council, and that since 1962 there has been a national commitment, backed by Parliament, to the concept of regionalization. In spite of this, and of the fact that in their control and ownership of hospital facilities, services, and staff, the county communes are backed and supported by indirect controls from the National Board of Health, the regionalization of secondary care services by hospitals is rather limited, particularly in the urban counties and large cities. Different explanations may be offered, and many have been volunteered to this observer by people involved in the situation.

First, as in the case of tertiary services, the counties have had the money to pay for services, without much concern for savings or avoiding duplication. Not until very recently have the taxpayers started revolting against the very high level of taxation. Also, not until recently have the increasing costs of medical and hospital care made benefits relatively less accessible, thus generating more concern about cost on the part of the county authorities.

Another explanation may be the existing structure, described earlier, which determines the considerable degree of independence of each hospital within its own budget. Moreover, the medical profession within the hospitals has been firm in wielding its influence as a powerful pressure group, not only at the institutional level but also at the county council level. It strongly resists, as indicated earlier, any delegation of responsibility to other institutions that it may interpret as threatening to curtail its prerogatives. Besides this professional concern for curtailment of responsibility that delegation in regionalization may imply, other factors have probably worked against regionalization; for example, the system of payment for ambulatory care—primary as well as secondary—on a fee-for-service basis that persisted until the 1970 reform. As observers in the United States have indicated,

> . . . when a . . . . hospital surrenders a program of care to another hospital, its medical staff stands to lose income from the care of private patients.[51]

Due to the influence that physicians have on hospital decisions, this might represent an insurmountable obstacle to regionalization.[52]

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[51] H. E. Klarman, *Hospital Care in New York City*, 325.

[52] V. Navarro, "The City and the Region; A Critical Relationship in the Distribution of Health Resources," 883.

To stimulate the process of regionalization, the National Federation of County Councils, the National Institute for the Planning and Rationalization of Health and Social Welfare Services (SPRI), and the National Board of Health have given great attention and interest to the administrative restructuring of health services in the county council of Stockholm, aiming at minimizing the constraints on regionalization that the present administrative structure implies.

Indeed, as will be discussed in Chapter 5, the restructuring of health services in the urban region of Stockholm and the establishment of medical blocks within each district are intended to redistribute the functions and responsibilities of the sector by types of care into medical, surgical, long-term, psychiatric, pediatric, and services blocks. These blocks could bypass the present institutional and administrative arrangements that work against the implementation of the model of regionalization.

Primary Care Services: Their Isolation

To what degree have the primary care services provided by the district officers been regionalized? If regionalization of primary care services refers to their coordination and integration with secondary and tertiary care services, then regionalization has been limited. As indicated earlier, the district officers work in solo practice, in charge of the vertical (ambulatory) patient as different from the horizontal (hospitalized) one.

The isolation of their work referred to earlier has further occasioned the suggestion of integrating them into the hospital sector, and grouping them in health centers in which personnel, facilities, and equipment could be delegated to them. This approach, however, has not passed the stage of the few pilot experiments across the country in which district nurses and social workers work in health centers together with district physicians.

Also, the coordination of the district officers with the hospital sector has not yet been implemented, the one exception being Stockholm, where they are under the same administration as the district medical director. What this new arrangement will achieve by way of integration of the district officer into the hospital remains to be seen.

HEALTH SERVICES AND THE LEVEL OF HEALTH IN SWEDEN—ARE THE SERVICES AVAILABLE ACCORDING TO NEED?

A discussion of Swedish health services would be incomplete without mentioning how these services may have affected the level of

health of the Swedish population. In other words, how effective are the health services? Obviously, any statement on effectiveness or ineffectiveness would depend upon the objectives of those services. And health planners are well acquainted with the problems, conceptual, and methodological, encountered in defining both objectives and the causal relationship between the health services and their expected effect on those objectives. Indeed, how much of the extremely low infant mortality in Sweden, 12.9 deaths/1000 live births (compared with 22.1 in the United States and 18.4 in the United Kingdom), is the result of extensive prenatal care covering 80% of the population and subsequent hospitalization at delivery, covering 98% of deliveries? Unfortunately, our ignorance of the cause-effect relationship between the system and the cure of most conditions calls for considerable caution in any health services evaluation, if we consider the minimization of mortality and morbidity as the objectives of health services.

Accepting, then, this constraint, we shall briefly describe some general indices of mortality and morbidity in Sweden, remembering that those overall quantitative and qualitative levels may or may not be related to the level of care provided by the Swedish health services. As in the United States and the United Kingdom, the three main causes of mortality in contemporary Sweden are heart disease, cancer, and stroke. The fourth and fifth causes of mortality in Sweden, however, are influenza and pneumonia (the same as in the United Kingdom), and the sixth cause is accidents (the fourth cause in the United States). It is noteworthy that suicide is the seventh cause of death (homicide in the United States), an item in which much political capital seems to have been invested, however wrongly. Indeed, one of the alleged ill effects of the individual security and permissiveness of the Swedish welfare state has been its high suicide rate. It is remarkable how this misinformed argument is still being repeated most uncritically in the supposedly well-informed press and even in academic publications.[53] Actually, Sweden (in spite of its accurate system of reporting suicides) has among the lowest suicide rate of any country in Europe; Hungary, Czechoslovakia, Austria, West Germany, Finland, Denmark, and others have much higher suicide mortality than Sweden.[54]

More meaningful than overall mortality (10.1/1000 people in Sweden

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[53] R. Huntford, *The New Totalitarians.*

[54] Actually, it is very likely that southern European countries (Spain, Italy, and France) have equally high suicide rates, but the moral connotations of suicide may result in a considerable underreporting of this cause of death in these countries.

versus 9.4 in the United States and 11.1 in the United Kingdom) is the age specific mortality. Table 11 shows that for every age group (except for age groups 5–14 and 75 and over), Sweden has a lower mortality than the United States, and is roughly comparable to the United Kingdom,[55] except for mortality in infants and the 45–54 and 55–64 age groups, which is lower in Sweden.

More relevant than an analysis of changes of mortality and morbidity in the study of health services effectiveness in Sweden, where chronic morbidity is quantitatively and qualitatively most important, is the study of how those health services may have affected the level and type of disability. Indeed, the health services in industrialized societies have more to do with care than with cure.[56] And it is in this taking care of problems and people that health services may be more effective. It is also in this realm that evidence is being accumulated to prove that medical and hospital care may be able to take care of and thus reduce the level of disability of the individual and of the population.[57]

Table 11. AGE-SPECIFIC MORTALITY IN THE UNITED STATES, SWEDEN, AND THE UNITED KINGDOM, 1965

Age	Deaths per 1000 population		
	United States	Sweden	United Kingdom
Under 1	24.1	13.3	20.5
1–4	0.9	0.7	0.8
5–14	0.4	0.4	0.4
15–24	1.1	0.7	0.8
25–34	1.5	1.0	0.9
35–44	3.1	1.9	2.1
45–54	7.4	4.4	5.8
55–64	16.9	11.3	15.1
65–74	37.9	32.3	32.0
75 and over	101.7	110.9	111.1
Average	9.4	10.1	11.1

Adapted from: O. W. Anderson, *Health Care: Can There Be Equity? The United States, Sweden, and England.*

[55] For an interesting comparison of the mortality and morbidity patterns in the United States, Sweden, and England, see O. W. Anderson, *Health Care: Can There Be Equity? The United States, Sweden, and England.*

[56] K. L. White, "Organization and Delivery of Personal Health Services: Public Policy Issues."

[57] For a discussion of the implications of changes in mortality and morbidity patterns for the organization and planning of health services, see V. Navarro, "Redefining the Health Problem and Implications for Planning Personal Health Services."

Table 12 shows different rates of physical disability and of visual and dental problems per 1000 adults by social class in Sweden today. The lower class has much higher rates of disability[58] (threefold) than the upper classes and a higher prevalence of visual impairments per 100 adults, with more than twofold impairment in the lower than in the upper classes. A similar pattern obtains for the prevalence of dental problems per 1000 adults by type of problem and by social class.

A question that obviously arises from these data is to what degree

Table 12. PERCENTAGES OF SOCIAL GROUPS WITH DIFFERENT DEGREES OF PHYSICAL DISABILITY AND VISUAL AND DENTALS PROBLEMS

Social group	Physical disability		
	Very disabled %	Disabled %	Decreased locomotive ability %
1 [a]	3.3	7.2	13.7
2 [b]	5.3	11.0	20.3
3 [c]	10.3	17.6	30.5

	Visual problems	
	Severe visual problems %	Visual problems %
1	1.3	4.8
2	2.2	5.6
3	3.3	8.7

	Dental problems			
	No teeth or only rest of teeth %	Poorly fitting dentures %	Poor own teeth %	Total poor teeth %
1	0.0	0.4	2.4	2.8
2	0.3	2.1	3.6	6.0
3	1.4	4.3	7.8	13.4

[a] Management and business; professions; upper civil service; university students; pensioners.
[b] Agriculture and trade; small business; supervisory personnel; technicians and office personnel; lower civil service; high school students; pensioners.
[c] Wage earners and small farmers; fishery and timber workers; unemployed; handicapped; other student categories; pensioners.

Adapted from: S. Johansson, *Den Vuxna Befolkningens Hälsotillstand,* Laginkomstutredningen (1972), 28, 48, 58.

[58] Disability is measured by the possibility of walking 100 meters without, with, or in spite of assistance: S. Johansson, *Den Vuxna Befolkningens Hälsotillstand.*

are the health services succeeding or failing in bridging the gap of health care among social classes. Indeed, health services in Sweden, as part of welfare state services, could be evaluated according to the degree that, within the overall aim of equalization assumed to be the objective of the modern welfare state,[59] they are minimizing the present inequalities in the level of disabilities among social classes. It would seem that health services, providing more care than cure, should be planned to reduce these social differences in the level of disability, following the dictum that availability of care should be correlated directly with the need for it. From the available information as presented in Table 12, however, it would seem that in Sweden, as Julian Tudor Hart has shown for the United Kingdom, the health services are not minimizing those inequalities.[60]

Indeed, the Swedish experience seems to indicate that the minimization of economic barriers to health care (greater in the United Kingdom than in Sweden), is necessary but not sufficient to correct what could be defined as the law of unplanned development, i.e., the availability of care tends to vary inversely with the need for it in the population served. The implication of this experience in Sweden and the United Kingdom should not escape defenders of the proposals for national health insurance in the United States. Indeed, the reduction of economic barriers to health care and public sharing of individual risks, the aim of a national health insurance, is no guarantee of eliminating the social inequalities of the differential social accessibility of available health care. Indeed, the gap between the levels of health among social classes in the United Kingdom is widening,[61] despite the fact that the constraints, which the proposed national health insurance in the United States is assumed to reduce, do not exist in Sweden and the United Kingdom.

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[59] G. Myrdal, *Beyond the Welfare State.*

[60] J. Tudor Hart, "Primary Care in the British National Health Services: Historical Evaluations and Future Possibilities."

[61] J. Tudor Hart, "Primary Care in the British National Health Services: Historical Evaluations and Future Possibilities."

Chapter 3

ECONOMIC, SOCIAL, AND HEALTH PLANNING IN SWEDEN AND THE RELATIONSHIP BETWEEN HEALTH AND ECONOMIC PLANNING

THE SWEDISH ECONOMY: AN OVERVIEW

Sweden is frequently referred to as a socialist country, usually with emotional connotations attached to that description. If a socialist economy, however, is defined as one where, among other characteristics, the majority of the means of production are publicly owned, then that definition is highly inappropriate for Sweden. In fact, the Swedish economy, notwithstanding the existence of a public sector, is dominated by private enterprise and ownership, just as is the economy of the United States. Only a subsidiary part of the means of production is owned by the state in Sweden. Actually, state intervention, regulation, and control in national economic and social planning aims at strengthening the private enterprises that predominate in the economy.[1] Table 13 shows the distribution of ownership of the main sectors of the Swedish economy in 1965, in terms of percentages of employees.[2]

Actually, over 90% of all industrial employment is private, with the cooperatives accounting for 4%, and national and local government for 6%. In terms not of employment but ownership,

> . . . almost all industry is privately owned, including 99% of shipping and

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[1] Ministry of Finance (Sweden), *The Swedish Budget 1967/1968.*

[2] E. Ödmann and G-B. Dahlberg, *Urbanization in Sweden; Means and Methods for Planning,* 24.

textiles, 98% of engineering, 95% of forest industries, 94% of steel and metal-working, 93% of banking, and 83% of the retail trade.[3]

Apart from private ownership of most of the means of production, a second characteristic of the Swedish economy is, again as in the United States, the large concentration of economic power in the hands of a relatively small number of corporations. Indeed, Sweden is one of the European countries with the highest degree of financial and industrial concentration. The 20 largest corporations are responsible for one-third of the total production in the country, and the first 100 corporations are responsible for over half of the country's production.[4] Moreover, within these corporations, the control of finance capital is highly concentrated in five banks, which represent the interests of the

Table 13. OWNERSHIP OF VARIOUS SECTORS OF THE SWEDISH ECONOMY, BY PERCENTAGE OF EMPLOYEES, 1965

Sector	State %	Cooperative %	Private %	Total %	Number of employees
Mining	80	0	20	100	13,000
Iron, steel and metal manufacturing	5	1	94	100	498,400
Quarrying	1	1	98	100	47,300
Timber, pulp and paper	3	3	94	100	142,500
Printing	2	1	97	100	47,300
Foodstuffs	4	34	62	100	73,300
Textiles and garment industry	0	1	99	100	87,000
Leather, fur and rubber products	0	5	95	100	32,800
Chemicals, chemical engineering	3	1	96	100	46,600
Manufacturing	5	4	91	100	988,500
Commercial banks	8	0	92	100	16,000
Retail trade*	1	16	83	100	273,000

*1960

Adapted from: E. Ödmann and G-B. Dahlberg, *Urbanization in Sweden: Means and Methods for Planning*, National Institute of Building and Urban Planning Research (Stockholm: Government Publishing House, 1970), 24.

[3] J. B. Board, Jr., *The Government and Politics of Sweden*, 240.

[4] There is an extensive bibliography on the economic concentration in Sweden. The first, and among the most comprehensive, is C. H. Hermansson, *Monopol och Storfinans-de 15 Familjerna*. The uproar caused by this publication resulted in the establishment of a Royal Commission to study the subject. Its report confirmed Hermansson's findings: Swedish Government Documents, SOU 1968:3,5,6,7.

"fifteen families" and two investment companies.[5] These seventeen groups have controlling interest in over 200 enterprises, responsible for about 25% of the total manufacturing output of the country.[6]

This high concentration of wealth and economic power has caused considerable concern among some sections of the Social Democratic government. It is of interest that their reaction to this concern has been different from the responses in other countries with similar concentration of economic power. Actually, instead of calling for nationalization (as did some sections of the Labor Party in the United Kingdom), or for antimonopoly legislation (as did certain sections of the Democratic Party in the United States), they called for more public controls over investment. Consequently, one of the actions taken by the Social Democratic government, in 1967, with some opposition from banking enterprises and industry, was the creation of a government-operated Industrial Development Bank to assist industries needing long-term capital. The purpose of this bank was to strengthen government control of the capital market. The starting capital was raised by a 1% increase in the turnover tax. However, whether this bank, which controls only about 6% of the flow of funds in the capital market, meaningfully influences the distribution of capital investment is questionable.[7] (See below, on the planning process, for elaboration of this point.) Actually, if the National Pensions Fund—the largest source of capital available to the government—were to be channeled through this bank, the government's impact on the capital market would be much greater than the bank's existing 6% share of capital flow allows. For this reason, the trade unions have been encouraging the rechanneling of the Pensions Fund through the Industrial Development Bank, with great resistance from the business community.

The Public Sector

By most European standards, the size of the public sector in Sweden is relatively small. In terms of employment, public employees, most being in the social services, represent only 20% of total national employment. Over half of that 20% is employed by the national government and most of the rest by local governments. In terms of production, the public sector accounts for 15% of the overall production of goods and services. However, public consumption and investment

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[5] See C. H. Hermansson, op. cit., which traces the concentration of the Swedish economy in the hands of fifteen families.

[6] J. B. Board, Jr., *The Government and Politics of Sweden*, 241.

[7] F. Fleisher, *The New Sweden: The Challenge of a Disciplined Economy*, 120.

account for over 28% of the gross national product, and taxes and social insurance generates 33% of the gross national product.[8]

More important than its overall size is the public sector's determining interest in certain sectors of the economy. The state occupies a strategic position in, for example, natural resources. There is significant public ownership of four of Sweden's main natural resources and related industry: 25% of the forestland, 90% of iron ore, 50% of water power, and 100% of atomic energy. Also, in transportation and communications, the state owns 95% of the railways, and appoints half of the members of the board of directors of the Swedish Broadcasting Corporation, which is otherwise organized as a private company.

The administration of this public ownership is either through state business agencies (referred to as affärsdrivande verk), such as the National Railways, or through state companies (aktiebolag), such as the publicly owned mining and manufacturing companies.

The state business agencies are within the civil service and are organized like the other agencies of the national government (see Chapter 1). They differ, however, in that they are more autonomous than those agencies, and have control of their own operating budgets.

The state companies, in the majority, are outside the civil service and their structure is similar to that of large private corporations, with boards of directors and shareholders, over which the corresponding Ministry has sole or controlling interest.

It is significant that both of these types of public enterprises, as well as the public sector in its present size and form, were for the most part already in operation before the Social Democrats came into power in 1932. Actually, some of the state enterprises date back to the 16th century. Indeed, the Social Democratic Party, although containing groups in favor of nationalizing banks, industries and other undertakings, has not nationalized any economic enterprises, with the recent exception, in 1970, of the system of distribution of drugs—the pharmacies—and those parts of the pharmaceutical industry considered necessary to permit control over that sector.[9]

At the local level, the local authorities—primary communes and county communes—own and control a number of enterprises, also administered either as local authority agencies or as public corporations (see Chapter 1 for a discussion of local authorities). The local au-

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[8] J. B. Board, Jr., *The Government and Politics of Sweden*, 243.

[9] The other exception was, in 1940, the creation, more than the nationalization, of public industry in the north of the country as a way of reducing unemployment.

thorities also own most of the social services facilities, e.g., the primary communes own the schools, and the county communes own the hospitals and other medical institutions.

Section I

THE NATIONAL AND REGIONAL PLANNING PROCESSES

NATIONAL PLANNING

The stated objectives of socioeconomic development in Sweden, as reflected in formal and informal communications from state officials in the different planning agencies, are: (1) full employment; (2) fair and politically acceptable income distribution, from individual to individual as well as between regions, areas and occupations; and (3) internal stability of prices and internal balance of payments.[10]

Within these goals, it is considered that the private sector, left to its own inclinations, would not ensure full employment, price stability or a balance of payments, a proper balance between consumption and investment, generally acceptable patterns of income distribution, or the social safety and welfare required for the running of the economy.[11] The state and other levels of government have thus intervened, through national planning among other measures, to direct the public sector and pressure the private sector to implement the policies necessary to achieve these goals. In this respect, the task of national planning is, first, to complete what the private sector fails to accomplish, and, second, to avoid or eliminate distorting tendencies that could handicap, slow down, or even conflict with the development of the private sector *per se*. In practice, then, the purpose of state intervention and national planning is the strengthening of the largest sector of the economy, the private sector. As Jean Monnet, one of the fathers of the Common Market, has indicated: ". . . better the business community convinces themselves that the only alternative to planning is nationalization." [12]

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[10] Swedish Government Documents, *Svensk Ekonomi 1966–1970 med Utblick mot 1980.*

[11] A. Lindbeck, "Prissystemet i Langtidsplanerigen."

[12] W. P. Blass, "Economic Planning European Style," 110. A similar point is made by A. Lindbeck, op. cit.

With this awareness, the business community in Sweden has for the most part perceived national planning and state guidance and influence as a means of strengthening (or some would say saving) the private sector, and thus, following an enlightened self-interest, has actively participated in that process.

The present system of planning was initiated in 1962, when the Economic Planning Council was established. Its tasks were to

> . . . act as an organ for consultations between the government, the business sector, the labor market organizations and research, on questions to do with the long-term development of the Swedish economy . . . . The Council is to follow current developments and discuss such problems as may arise in the maintenance and improvement of the rate of progress in the Swedish economy.[12]

Its members include, besides the Minister of Finance (the chairman of the Council), Members of Parliament, and representatives of the Federation of Employers, the trade unions, banking, the Labor Market Board, and two professors of economics. Other advisory bodies have been created in other economic and social fields, such as the Health Planning Council (see Chapter 4 on national health planning) to coordinate and relate sectoral planning (e.g., health planning) with the national development process.

The task of coordinating the work of the Economic Planning Council and related councils is the responsibility of the Secretariat for Economic Planning in the Ministry of Finance. It is also the responsibility of that Secretariat to develop long-term economic projections, referred to as the long-term plans, whereas the long-term state budgets are the responsibility of the budget department of the Ministry of Finance. It is interesting to note that state planning and budgeting functions are the responsibility of two different groups within the same Ministry, the Ministry of Finance, with the budget department functionally and administratively dependent on the Secretariat for Economic Planning. It is this author's impression that this dependence facilitates the implementation and control of the plans by budgeting, and that, due to this administrative arrangement, Sweden avoids a problem common in countries where budgeting is the responsibility of a department administratively independent from, or at the same level as, the planning department. That problem is that the budget group seldom follows the plans prepared by the planning group, making the work of the latter irrelevant. Figure 10 shows the organization of the Ministry of Finance in Sweden.

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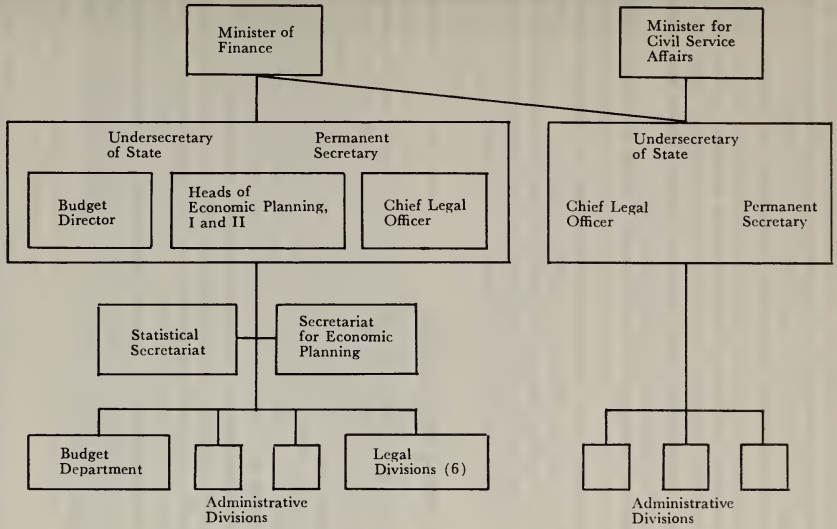
[12] Ministry of Finance (Sweden), *The Swedish Budget 1967/1968*, 119.

FIGURE 10. ORGANIZATION OF THE SWEDISH MINISTRY OF FINANCE



Adapted from: P. Vinde, *Swedish Government Administration: An Introduction* (Stockholm: The Swedish Institute, 1971), 22

The Methodology of National Planning

The methods of Swedish national planning can be classified under two headings, "educative" and "coercive". Educative methods are aimed at clarifying the benefits that the groups affected by the planning process may obtain from their participaion in that process: first, by disseminating information relevant to the needs of the different groups and sectors within the economy, and, second, by participating in the preparation of the plans. These educative methods rely on the enlightened self-interest of the major economic groups as the motivation for their participation in the planning process. Control and coercive methods are based on actual regulatory powers.

These two principal sets of methods are utilized in all four elements which make up the Swedish national planning process: (1) long-term macroplanning; (2) long-term state budgeting; (3) long-term sectoral planning; and (4) anticyclical planning.

The first three elements deal with the long-term allocation of resources and growth, while the fourth deals with short-term stability (price stability and balance of payments) and employment.

National Long-Term Planning

Long-term planning goes back to 1947, when it was used in connection with the Marshall Plan.[14] The long-term plans are actually aggregate 5-year projections of the different sectors of the economy, and are aimed at investigating, surveying, analyzing, and mapping out development trends and policy or strategy options for the government.[15] Also, the 5-year plans establish the level of the government's expectations from the private sector, serving as a means of communication from the government to the nongovernmental economic units.[16]

The first objective is to provide information to the government (primarily at the national level) concerning its policy options, and is a result of the government's belief that regulation of the nature, type, and time preferences of economic growth should be a public responsibility and thus subject to political value judgment. The implementation of that regulation at the macrolevel is mainly accomplished through fiscal and monetary policy.

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[14] Five-year economic projections have been developed since then for the periods 1951–55, 1956–60, 1960–65 and 1965–70. These projections are published in the Swedish Government Documents SOU 1948:45, 1949:15, 1951:30, 1952:11, 1956:53, 1957:10, 1957:22, and 1960:10–11.

[15] I. Svennilson, *Planning in a Market Economy.*

[16] Ministry of Finance (Sweden), *The Swedish Budget 1967/1968,* 110.

The second objective is to provide information to the private sector, based on the awareness of that sector's need for information on long-term developments in the entire economy and in its various sectors. It is noteworthy that this is a reciprocal process of information sharing, both from the government to the private sector and vice versa. Actually, the preparation of the long-term plans is a laborious process that usually takes two years and includes surveys of 5-year plans and the expectations of thousands of economic units. Worth underlining is that for some social enterprises, such as education and health, in which capital investments are large and periods of gestation long, the surveys are of 10- and 15-year plans, instead of 5-year plans. Actually, most of the social sectors are surveyed for such long periods (see Section II and Chapter 4).

Characteristic of this process is that the collection of information is decentralized and conducted by statistical units at the local level, in local trade associations or specialized government agencies. Also, the data from the industrial private and public enterprises is used only by state statisticians for their aggregation according to the different sectors of the industry, and the published estimated projections are overall aggregates by sector. Before their publication, however, these initial aggregates are discussed by the respective trade associations, which may lead to revisions of the original estimates, revisions that can be either in terms of the sector as a whole or of the constituent industrial enterprise. The local authorities, e.g., the county communes, also prepare long-term projections for their different areas of activity, e.g., education, health services, and others, that have to be sent to the National Board of Health. (See Chapter 4 on national health planning.) In addition to this inductive information, generated by the industrial private and public enterprises, there also is deductive information, generated by research studies analyzing, for example, past trends in production and demand.

On the basis of the survey information collected by sector from the different industrial enterprises, and of the studies carried out by the research institutes and agencies within and outside the government, the Secretariat for Economic Planning of the Ministry of Finance prepares a crude aggregate of 5-year plans and estimates.

These crude projections are later modified to balance aggregate demand with aggregate supply of resources. The technical and political balancing of supply and demand within each sector and among sectors is done by the Secretariat for Economic Planning of the Ministry of Finance according to an econometric model of the national eco-

nomic system.[17] These projections are also modified in terms of politically desirable changes. Once the final projections by sector are completed and modified, the fiscal and monetary policies that must be implemented to reach the desired political objectives are determined and published with the final 5-year plan. These 5-year plans, then, contain the 5-year economic and social projections, modified to meet political considerations and the fiscal and monetary policies of the national government.

An Initial Appraisal of the Long-Term Projections and Plans

From the Swedish experience, it would seem that the main advantages for the private sector of long-term planning are the following:

1. To minimize uncertainty and the conservative attitude toward investment and growth that uncertainty usually fosters;
2. To minimize bottlenecks in the production process, since information is provided not only about estimates of aggregate demand but also about supply and demand by sector and their interdependencies, thus providing information to the private sector on how avoid bottlenecks; and
3. To allow for more coherent and rational policy making by the private enterprises, through the provision of information on governmental policy and its effects on the entire economy.[18]

A fourth, unspoken advantage, but of no less importance for at least the large private enterprises, is their participation in the process of estimating the sectoral projections and their interrelationships. Indeed, preparation of the plan has political as well as technical components.[19] As indicated before, the principal economic groups, such as banking, trade unions, commerce, and others, participate formally at the national and informally at the local level in discussions of the estimated projections, and modifications of the estimates are based on these discussions. It is in this process, then, that assumptions, values, and interests are translated into aggregate projections in terms of the weight given to the different indices and indicators to be used later in the national economic model.

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[17] A basic feature of this model is the input-output table where the elements of each row show the use made of the output of each industry. To see the use of this table in economic planning, cf. National Bureau of Economic Research (United States), *Input-Output Analysis: An Appraisal.* For a modification of the concept of input-output tables for predictive purposes in health planning, see V. Navarro, "A Systems Approach to Health Planning," 94.

[18] Personal communication, Secretary for Economic Planning, Ministry of Finance, 1971.

[19] Actually, as in any other country the political considerations are far more important than the technical ones in the process of plan preparation.

Worth underlining as an important characteristic of the long-term planning process in Sweden is that the participation of these economic groups is formalized at the national level, but not at the local level (where it may occur informally), and their grouping is not by economic sector, e.g., agriculture or industry, but by level of activity. This latter characteristic of preparing the plan differs from the French system, for instance, in which local and regional meetings of the economic groups, apart from national ones, take place, sector by sector.[20] A process similar to that in France has developed in the United Kingdom in the form of the Economic Development Committees.[21] Sweden's small size seems to make these formal sectoral meetings at the local level unnecessary.[22] Still, although the meetings with the Secretariat for Economic Planning take place only at the national level, they do provide a unique opportunity for influencing the final form of the long-term plans, and the informal meetings at the local level strengthen this opportunity. The unequal influence exerted by these economic groups may result, of course, in strong biases and even conflicts within the planning process. In France, for instance, the trade unions and most of the political parties of the left participate only to a limited degree in the local and regional economic commissions for preparation of the plan, because of their assumption that big capital has the determining influence in shaping projections and indicators.[23] The response of the corresponding parties and trade unions in Sweden, as in the United Kingdom, however, has been one of full participation and involvement, not of detachment, as in France.

Apart from the educative component, the long-term plans also provide guidelines for governmental policy, in terms of monetary and fiscal policy, for reaching the political objectives desired. For instance, the creation, in 1967, of the Industrial Development Bank, aimed at influencing the investment policies of the private sector, was considered an additional means of stimulating investment along the lines proposed in the long-term plans. And the increasing size of public investment follows a long trend, begun in the early 30's. It is interesting in this respect that the percentage of public investment increased from 28% in 1939 to 42% in 1963, while private investment simultaneously declined from 72% to 57%. Table 14 shows the distribution of gross investment in 1963 and earlier.

A further means of stimulating the implementation of the long-

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[20] S. S. Cohen, *Modern Capitalist Planning: The French Model.*
[21] G. D. Vaughan, "Economic Development Committees."
[22] Ministry of Finance (Sweden), *The Swedish Budget 1967/1968*, 110.
[23] S. S. Cohen, op. cit.

term plans is the long-term budget. Indeed, the long-term plans or projections serve as a basis for the elaboration of the long-term budget.

The Long-Term State Budget

This budget, which covers five years, indicates what resources are needed in the public sector to attain the objectives established by government and Parliament (the cost of the policies proposed and accepted by both bodies) and determines the budgets for the programs of the central government sector. The budget department of the Ministry of Finance prepares these long-term budgets and attempts are made to coordinate them with the long-term plans prepared by the Secretariat for Economic Planning of the Ministry. For example, the expansion or contraction of the public sector is primarily based on the availability of labor as indicated in the long-term plans. A main task of these long-term budgets is to assure consistency among the long-term plans, the sectoral plans, and the state budget.

Table 14. DISTRIBUTION OF GROSS INVESTMENT IN VARIOUS ECONOMIC SECTORS OF THE SWEDISH ECONOMY

Sector	Billion kronor	Gross investment %			
	1963	1938/1939	1946	1955	1963
Industry and crafts	6.4	19.4	19.6	20.7	22.6
Power stations and distribution	1.4	3.4	3.9	5.6	4.9
Agriculture, forestry, fisheries	1.5	8.2	8.0	6.7	5.4
Subtotal	28.4	100.0	100.0	100.0	100.0
Housing	5.7	30.3	32.1	20.8	20.0
Transport and communications	6.7	24.7	22.1	23.3	23.7
Roads and highways	1.8	5.6	3.0	5.4	6.5
Commerce	1.1	2.5	1.1	2.4	3.9
Non-military public services	3.4	7.6	6.2	10.4	11.9
Education	1.2	2.3	2.1	3.6	4.1
Health and welfare services	0.8	?	1.3	2.3	2.6
Water supply and sewage	0.9	0.9	1.4	2.6	3.2
Other	0.5	4.5	1.4	1.8	1.9
Defence	2.1	4.0	6.9	8.8	7.5
Total	28.4	100.0	100.0	100.0	100.0
Private investments	16.3	72.1	70.5	57.0	57.5
Public investments	12.1	27.9	29.5	42.9	42.5
Total	9.3	31.0	31.6	33.1	32.8

Adapted from: E. Westerlind and R. Beckman, *Sweden's Economy: Structure and Trends* (Stockholm: The Swedish Institute, 1965), 46.

Sectoral and Social Planning

The major part of social planning is within the public sector of the economy because state, county and local governments are responsible for the production and operation of social services (see Chapter 2). The need for planning in these social sectors outside the purview of the private economy arises from the need to ensure the rational allocation and utilization of resources and to balance the development of these social sectors with the overall development of other sectors of the economy.

At the state level, the planning process occurs at three levels: first, the Cabinet, Parliament, and the Royal Commissions, responsible for goal setting and the introduction of new policies; second, the Ministries responsible for preparing long-term plans and policy affecting structural changes and major redirections; and third, the agencies and public enterprises responsible for implementing the long-term policies and making the necessary short-term adjustments to reach those policies.

State planning in the social sectors is also in great part directed at the local authorities—primary communes and county communes—which are responsible for the provision and distribution of most of the social services, particularly health services. In this respect, the long-term plans serve both as a means of clarifying national standards for the various social services, and for conveying information on the long-term trends of development regarding the demand for services, such as forecasts of population growth, income levels, and employment. Also, because the local authorities depend in large degree on the state for funding, the long-term plans and budgets provide an outline of the allocation of resources among counties and communes.

It is worth noting that the state also plans for and directly controls, although it does not own, housing and agriculture. These two sectors have been kept outside the domain of the market system for political reasons, to keep prices lower in the case of housing, and higher in the case of agriculture. The objective of state planning in these sectors is to achieve a balance of these sectors within the overall development of the total economy.

Anticyclical Planning [24]

Anticyclical planning is short-term planning aimed at maintaining

[24] Most of the information presented in this part was obtained during meetings with officials of the Ministries of the Interior and of Health and Social Affairs.

full employment in times of recession, and stability of prices and balance of payments in periods of expansion. A major tool for anticyclical planning, in addition to fiscal and monetary policy, is the labor and public works policy as reflected in the state and local budgets.

As indicated earlier, one objective of development is to maintain full employment and keep unemployment below 1.5% of the labor force. Instrumental to this policy is the National Labor Market Board, a state agency dependent in terms of policy on the Ministry of the Interior.[25] The Board is made up of representatives from government, management, and labor. The National Board has regional branches—almost one per county commune—with local labor market boards including, in addition to state government officials, representatives of management and labor from the local area and officials appointed by the local authorities. Attached to the regional labor boards are the local employment offices that serve administrative functions, e.g., they pay unemployment benefits at the local level. The objectives of the National Board are to combat unemployment, make labor available to industry, and prepare labor and industry for structural changes.

The first objective is possible because the National Labor Market Board controls a sizeable appropriation for public works as well as considerable private investment in construction. Regarding appropriations for public works, all capital investment by the state or local authorities for a hospital, school, or any other facility above 300,000 kronor has to be approved by the National Labor Market Board. Also, the Board has a large reserve of public projects, such as the construction of hospitals, health centers, or schools, whose initiation depends on its decision, and these projects may be activated or postponed depending on the employment requirements for the specific area or region. Also, since about 97% of housing in Sweden is built with government loans, the government, through the Labor Market Board, has considerable leverage to increase or slow down building, according to the employment situation. Indeed, the Labor Market Board controls the issuance of building permits (both public and private), recommends when work should be started, and determines both the time schedule for the project and the composition, type, and nature of the construction force.

Also, it is significant that in order to influence investment policies by the private sector, the government allows considerable tax advantages to capital if part of its profits are deposited in the Bank of Sweden for

[25] Recently there has been some talk by the government of moving this Board from the Ministry of the Interior to the Ministry of Finance. The main reason for this change would be to allow better coordination between labor market policy and economic policy.

varying periods of time (not less than 5 years), and the government can use those funds as the Labor Market Board and the Ministry of Finance decide.

In addition, the Labor Market Board has at its option other policies conducive to the movement of jobs to people. A recent policy, for instance, is to offer tax advantages to large corporations on the condition that when they invest in the south, an amount equal to one-quarter of that investment is invested in the north, the poorest part of Sweden.

The second objective, that of moving people to jobs, is realized by a large vocational training program controlled and run by the local labor market boards. Approximately 10% of the labor force at any given moment is in these training programs. Also, the local labor market boards offer subsidies to employers who take on handicapped employees. Another policy of local labor market boards, geared to the objective of making labor accessible to industry, is that of paying for the travel expenses of moving employees and their families to new jobs when existing ones are closed down.

The third objective, preparing labor and industry for structural changes, is made possible by the local labor market boards' requirement that employers give ample notice, over one year, to the boards of any layoffs affecting more than 1000 employees. For smaller layoffs, employers have to give six days notice.

Since all unemployed have to register with the local market boards to collect unemployment benefits, their network constitutes a very sensitive data gathering system that allows the National Board to detect, and to a certain degree, predict, changes in the employment situation within a fairly short period of time.[26]

REGIONAL PLANNING

The established objectives for regional economic and social policy in Sweden are (1) to promote a spatial distribution of economic activities that leads to full utilization of the country's labor and capital resources and is conducive to rapid economic growth; (2) to contribute to an equitable distribution of the standard of living; (3) to provide for an equitable distribution of social services among regions within

[26] The Labor Market Board is not without critics. Actually, it recently has been accused of being too sensitive to the influences and pressures of industry and too little to the concerns of labor. Also, some of its policies have been criticized as unfair. Among these are the policies of stopping unemployment cash benefits when workers refuse to leave their place of settlement and accept the jobs offered by the local labor boards, even where the new jobs are located at distances of more than 1000–1500 km from their homes.

the country; (4) to contribute to the social security of the individual during, before, and after structural changes; and (5) to contribute to the pattern of population and resources favorable to the national defence.[27]

To reach these objectives, the different levels of government—state, regional, county, and commune—follow the policies of

1. Overall location of industry conducive to a balanced regional development within the country;
2. Overall manpower and labor policy;
3. Coordination of sectoral planning with regional planning, with combination at the regional level of the various sectoral planning processes;
4. Community development, providing the physical and social infrastructure for balanced regional development;
5. Physical planning conducive to the better management of natural resources with preservation of nature and culture.

The first two policies have been discussed in the first part of Section I, which describes the influence of government on the investment policies of both the public and private sectors, and the anticyclical planning and functions of the Labor Market Board.

The third policy, to coordinate sectoral planning with regional planning, is a main objective of the Governor's Office, its board and the Economic Planning Council and Secretariat attached to the provincial government (see Chapter 1 for the structure of provincial government). As indicated earlier, the Governor's Office has been restructured, in 1970, to permit better regional planning and coordination of the different sectoral plans developed in the public sector either by the state agencies, by the local authorities, or by industry. A Planning Council in each province advises the Governor on overall development policies for the province and examines and evaluates applications for grants-in-aid from the public or from the private sector. These grants-in-aid include construction grants for facilities in the health sector for the county communes.

Furthermore, a Secretariat for Planning has been created in the Governor's Office which acts as the staff for the Planning Council. As was pointed out in Chapter 1, most of the regional offices of the state agencies have been moved to the Governor's Office for improved co-

[27] See Swedish Government Documents, *Aktiv Lokaliseringspolitik* and *Arbetsmarknadspolitik;* E. Bylund, "Policy of Location and Problems of Sparsely Populated Areas in Sweden"; and T. Hermansen, *Case Studies on Information Systems for Regional Development, Volume I: Sweden.*

ordination of their sectoral planning with regional planning, which in part is a responsibility of the Governor's Office.

Specific objectives of the regional plan prepared by the Governor's Office are (1) to provide information to the state agencies and their regional offices for decisions about the distribution of resources (grants-in-aid and other funds) available for regional development purposes; and (2) to provide guidance for the decisions taken by the Governor's Office itself in certain areas falling within its exclusive responsibility, such as loans for housing construction, or permits for physical location of facilities, including health facilities.

At the national level, a Regional Development Council was appointed in 1970, consisting of representatives of management, the trade unions, the Federations of County Councils and Primary Communes, and other interested organizations. Its objective was to establish policies for regional development within Sweden. Also, a Secretariat was established within the Ministry of Labor and Housing which acts as the staff for the Council and coordinates, at the national level, the regional developments that take place at the provincial level. A main responsibility of that Secretariat, and also of the Regional Development Council, is to coordinate, and synchronize between regions, their own regional plans with the long-term plans prepared by the Secretariat for Economic Planning of the Ministry of Finance discussed earlier. This coordination includes the health sector, which is mainly a responsibility of the county communes.[28] Coordination of the health sector at the national and regional levels is discussed in Section II.

The Methodology of Regional Planning [29]

The preparation of the regional plan is an elaborate process involving the state agencies responsible for state sectoral planning, the county councils primarily responsible for health care planning, the municipalities responsible for the social, personal, and environmental health services planning, and the private sector. This involvement and participation takes place in a number of settings, especially in the Planning Council of the Governor's Office, which includes representatives of the major economic sectors within the region. Complementing this participation are discussions of the initial drafts of the regional plans

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[28] Ministry of Labor and Housing and Ministry of Physical Planning (Sweden), *Regional Policy and Planning in Sweden.*

[29] Most of the information in this section was obtained from personal communications with officials of the Secretariat of the Regional Development Council.

that take place in the corresponding committees of the local authority councils.

What does the regional plan include? Actually, each regional plan contains the following:

1. A demographic forecast for each commune block, prepared according to assumptions of growth, centrally determined and applicable to the whole country;
2. A forecast of future manpower needs for each commune block, estimated according to local circumstances and assumptions as perceived by the Governor's Office;
3. A forecast of the planned commune activities, by commune block, with the various programs projected by the Governor's Office with regard to employment, communal equalization of living conditions, and public investment. Health activities, although run by the local authorities, are also included since they generate and determine measures in the regional plan related to employment, living conditions, and public investment (see also Chapter 4).

The coordination and integration of regional planning with long-term planning and sectoral planning takes place at the national level in the Division of Regional Planning of the Ministry of Labor and Housing. The methods followed for this coordination and integration have three stages (see Figure 11).

The first stage provides estimates of the regional distribution of capital and labor required to meet the goals of the long-term plan. At that stage, a comparison is made between the regional distribution of population, labor, and investment, as estimated by the various regional plans, and the population, labor, and investment estimates by each sector, projected by the long-term plan. Because these two estimates are unlikely to coincide, they are modified following a model which,

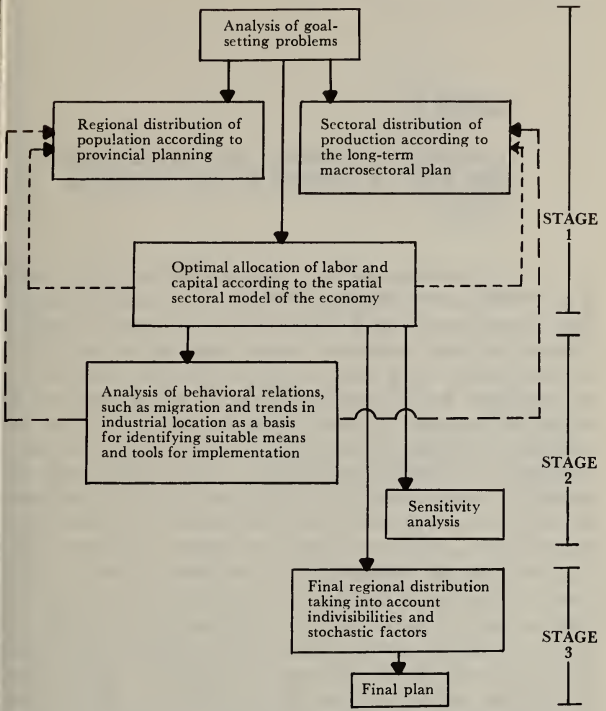
> . . . is designed as a linear programming model distinguishing between international, national and regional sectors, and between regions with respect to degree of agglomerativeness, taking as the objective the minimalization of total investments subject to the other goals introduced as side-conditions.[20]

The second stage of integrating levels of planning includes an analysis of the allocation of resources with specific analysis of

> . . . (i) the means and tools for steering the interregional resource alloca-

[20] T. Hermansen, *Case Studies on Information Systems for Regional Development, Volume I: Sweden*, 49.

FIGURE 11. A MODEL OF INTERREGIONAL AND INTERSECTORAL COMPATIBILITY


Analysis of goal-setting problems
Regional distribution of population according to provincial planning
Sectoral distribution of production according to the long-term macrosectoral plan
STAGE 1
Optimal allocation of labor and capital according to the spatial sectoral model of the economy
Analysis of behavioral relations, such as migration and trends in industrial location as a basis for identifying suitable means and tools for implementation
STAGE 2
Sensitivity analysis
Final regional distribution taking into account indivisibilities and stochastic factors
STAGE 3
Final plan

Adapted from: T. Hermansen, *Case Studies on Information Systems for Regional Development, Volume I: Sweden* (Geneva: United Nations Research Institute for Social Development. Report No. 70.S, 1970), 50.

tion, (ii) the opportunity costs of the location policy arising from the need to locate industries in other regions than those which might have given the highest national return, (iii) the costs of the total amount of subventions and reallocation subsidies that may be necessary to pay in order to implement a particular policy.

The third stage includes analysis of the actual allocation of resources among regions, by sectors and regions, taking into account indivisibilities and relationships among sectors.[21]

Section II

LONG-TERM PLANNING AND BUDGETING IN THE HEALTH SECTOR AT THE REGIONAL LEVEL

In the previous section, a description and appraisal was made of the Swedish national planning process at the national and regional levels. In this section the different stages of that process—long-term planning, long-term budgeting, sectoral planning, and anticyclical planning—for the health sector at the regional level, where most of the planning of health services takes place in Sweden today, are described and appraised. It should be pointed out at the outset that these stages vary from region to region and from county to county. Actually, in the United States and in other countries where the majority of health services are in the private sector, an argument frequently used against public control and regulation, let alone ownership of health services, is that public intervention would add an element of rigidity and uniformity, felt to be undesirable for the health sector. In the light of the Swedish experience, however, where the health services are funded, regulated and owned by the public authorities, primarily the local authorities, it would seem that this assumption has not proved to be correct. Indeed, Swedish health services, both in their organization and their planning, are far from uniform and monolithic, presenting great variety and diversity. Within this variety, however, there are some characteristics common to both their organization and their planning process. These common characteristics will be described and appraised in this Section.

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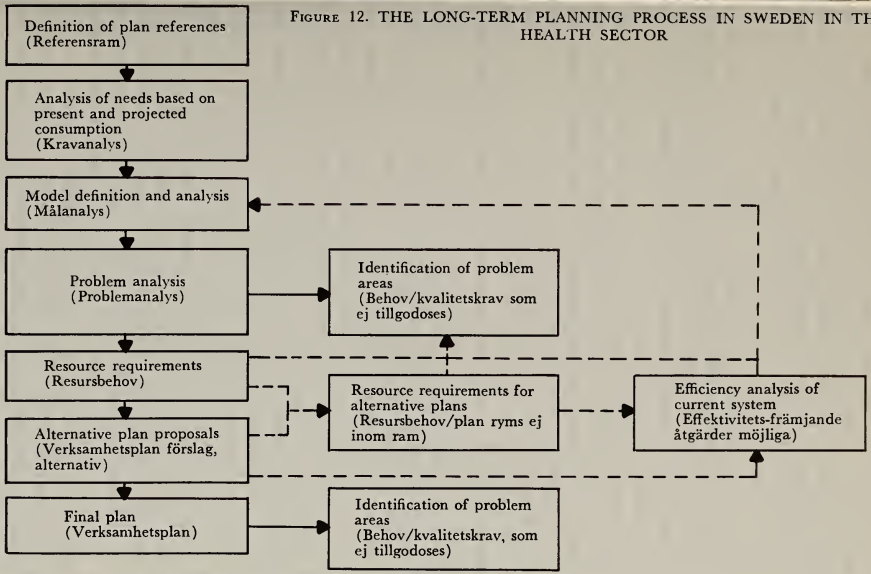
[21] For detailed information on this method, see: A. E. Andersson and G. Guteland, *En Regional och Sektoriell Modell för Konsistensprövning av den Nationella Langtidsplaneringen och de Regionala Utvecklingsplanerna; A. E. Andersson, Regionalekonomisk Utveckling och Politik;* G. Guteland, *Regionala Produktions-betingelser i Sverige.*

FIGURE 12. THE LONG-TERM PLANNING PROCESS IN SWEDEN IN THE HEALTH SECTOR


Definition of plan references (Referensram)
Analysis of needs based on present and projected consumption (Kravanalys)
Model definition and analysis (Målanalys)
Problem analysis (Problemanalys)
Identification of problem areas (Behov/kvalitetskrav som ej tillgodoses)
Resource requirements (Resursbehov)
Resource requirements for alternative plans (Resursbehov/plan ryms ej inom ram)
Efficiency analysis of current system (Effektivitets-främjande åtgärder möjliga)
Alternative plan proposals (Verksamhetsplan förslag, alternativ)
Final plan (Verksamhetsplan)
Identification of problem areas (Behov/kvalitetskrav, som ej tillgodoses)

Adapted from: Göteborg Health Services Council, *Sjukvårdsplan för Göteborg: Perspektivplan för Perioden 1970–1980* (Göteborg: 1970), 9.

THE LONG-TERM PLANNING PROCESS AND ITS STAGES

The long-term plan covers periods from 10 to 25 years and is revised every three years. Prepared by the long-term planning division of the county board (see also Chapter 1) in consultation with several affected groups, such as the medical profession, it serves as a frame of reference and set of guidelines for the long-term budget, and must be approved every three years by the county council.

Plan preparation varies from county to county, and its degree of sophistication likewise varies, depending on the size of the county, among other factors. The following description applies to the city of Göteborg [32] whose planning process (see Figure 12) is somewhat similar to that of other large counties.

The *first stage* in the preparation of the plan is the definition of the political and economic framework within which the preparation and the implementation of the plan takes place. It includes the definition of goals, objectives, values, terms, concepts, and others, and is referred to as the frame of reference of the plan (referensram).

The *second stage* is the analysis of needs (kravanalys), which includes analysis of both the present and the projected situation in the health sector. This step can be a very lengthy exercise, lasting two or three years, and involving physicians (mainly the heads of clinical departments of hospitals) and other professionals in addition to the staff of the long-term planning division. This stage includes analysis of the present and projected consumption of health services and health resources. These resources are divided into inpatient and outpatient service categories, and their consumption is analyzed separately. For hospital and institutional services, utilization statistics are collected annually and analyzed to define trends of utilization. Also, special surveys are made, aimed at defining misutilization of hospital resources. For example the Göteborg health planning agency recently developed a survey compiling a daily inventory of inpatients at the hospitals located within the region. Following this survey, a group of experts in the delivery of medical care from the Göteborg Hospital and Health Planning Council, with the clinical heads of the surveyed departments, defined the type of ward and institution that would best meet the medical needs of the inpatients, and compared their findings to the actual placement of inpatients. They found, for instance, that 20% of the patients in internal medicine wards could be better cared for in beds for long-term diseases.

The known demand for hospital care—analyzed, corrected, and defined by type of hospital services—is expanded to include the unknown need

[32] Göteborg Health Services Council, *Sjukvardsplan för Göteborg.*

for care. In the Göteborg long-term plan (1955–1975), this was done by arbitrarily increasing the aggregate regional demand for hospitalization by 10, 20, or 30% and offering three different alternatives according to the subjective estimates of the size of that unknown need.[33] Thus, the number of required hospital resources comprised those expected to meet the current and projected total demand for hospitalization, taking into consideration the corrections and additions mentioned above, for the period 1955–1975.

For ambulatory services, analysis of present demand is made from ambulatory utilization statistics collected by the insurance offices. As for future demand and because of the polarized age structure of the Swedish population, the regional planners calculate future demand by using as their index the "consumption unit," which reflects differences in utilization by various age groups, rather than aggregate utilization or consumption by the total population. One example of this approach is presented in the Göteborg plan, in which the mean annual number of physician visits for each age group per year was related to the mean annual number of physician visits for all age groups (231.6 visits per 100 persons) for the same year. In this way, the consumption unit, considered to measure the proportional consumption per age group, was obtained as shown in Table 15. The total number of consumption units, labeled the "consumption volume index," was estimated for the region by multiplying the consumption unit by the projected population for Göteborg in each age group for 1963, 1970, 1975, and 1980. Using this method, changes in the age structure of the population were taken into account in projecting future utilization.

To determine future consumption by categories of ambulatory care, in the 1965–1980 Göteborg long-term plan an analysis of utilization by type of facility and by age group was made for the period 1955–1965. The trend was then projected to estimate the total consumption volume index by type of ambulatory care, by age, and by year for the period 1966–1980. In this trend analysis, for instance, an increase in the use of outpatient departments and a decrease in the use of solo practitioners by older groups was observed and projected for the future. The required number of the various types of ambulatory resources was calculated as the amount needed to meet the present and future demand, given by the consumption volume index.

The method of consumption units to estimate demand is far more accurate, sensitive, and useful for estimating required resources than methods based on the level of overall demand of the whole population.

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[33] Göteborg Health Services Council, *Sjukvardsplan för Göteborg*, 28.

Table 15. ANNUAL NUMBER OF CONSUMPTION UNITS PER PERSON IN TERMS OF ANNUAL PHYSICIAN VISITS IN GOTEBORG, 1967

Age group	Number of visits per 100 persons (V) [1]	Number of consumption units per person (C.U.) [2]
0–15	125.0	0.540
16–19	154.0	0.665
20–29	196.9	0.850
30–39	236.0	1.019
40–49	274.9	1.187
50–59	311.1	1.343
60–66	345.2	1.491
67 and over	308.9	1.334
Mean number of visits ($\overline{V}$)	231.6	

[1] Data taken from Swedish National Insurance Board Study, 1963.

[2] C.U. = $V/\overline{V}$, for example: C.U. for age group 0–15 years = 125.0/231.6 = 0.540.
Adapted from: V. Navarro, "Methodology on Regional Planning of Personal Health Services: A Case Study: Sweden," *Medical Care*, 8:386–394 (1970), 389.

This "consumption unit" method permits (1) differentiation between the different levels of consumption by different age groups, and (2) comparison by use of a sole index of the different age-specific consumption rates of the population. The use of such methods in the United States, for instance, would allow the country to plan resources based not on arbitrary overall consumption ratios of the whole population, but on its age-specific consumption ratios.

The *third stage* of long-term plan preparation defines the type of regional model of delivery of care that is recommended as an objective of the long-term plan (malanalys). It involves assessing the types of services required at each level of care—primary, secondary, and tertiary—their physical location, and the minimum catchment area for each service for each level of care. The optimum size of the model population to be served in each region is determined by ascertaining the minimum number of persons needed to supply a sufficient clientele for the teaching, research, and services activities for the optimum size of the superspecialty department (neurosurgery, plastic surgery, thoracic surgery, child surgery, special cardiology) at the regional hospital center.[34] Thus, in the Göteborg plan the heads of the clinical departments of the teaching institutions made population requirement estimates by defining the minimum size of the specialized departments and the desired bed/population ratio for each.

[34] A. Engel, *Regionsjukvarden*. For a description (in English) of the Swedish regionalized health services, see A. Engel, "Planning and Spontaneity in the Development of the Swedish Health System."

For example, the heads of the departments of plastic surgery decided that 60 beds constituted the number required to warrant a full-time service. They also placed the desired ratio of plastic surgery beds to population at 5.5 per 100,000 persons for all of Sweden. By coordinating the figures for number of beds and optimum ratio to population, the minimum size of the region needed to support such a department was established at approximately one million persons [(60 × 100,000) / 5.5].

This stage, of course, requires a close working relationship with and considerable participation of different professional groups such as the medical associations, as well as other divisions within the board, such as physical planning, and the Planning Council and Secretariat of the Governor's Office (see Section I). The coordination between long-term planning in the health sector, which is the responsibility of the county board and its division of planning, and the long-term plan for the region, which is the responsibility of the national and regional state agencies and the Governor's planning staff, is partly initiated at this stage.

The *fourth stage* in long-term planning is the definition and analysis of the gaps between the desired organizational goals, operationally defined in the third stage, and the present and the projected situation, to determine whether or not there should be changes (problemanalys). Problem areas requiring extra resources are identified (behov/kvalitetskrav som ej tillgodoses).

The *fifth stage* covers the calculation of required resources (resursbehov), within the economic and political constraints set for the planning division by the county boards and councils.

The *sixth stage* provides the operational definitions of the alternative plans required to reach the desired organizational model within the given economic and political constraints (verksamhetsplanförslag, alternativ).

In the calculation of required resources, the fifth stage of the process, and in defining alternative plans, the sixth stage, consideration is paid to the alternative plans that may require extra resources (resursbehov/plan ryms ej inom ram) or require an increase in the efficiency and effectiveness of the current system, without adding extra resources (effektivitetsfrämjande atgärder möjliga).

The *seventh stage* is the final choice of the best alternative (verksamhetsplan), with identification of those gaps that will remain unsolved at the end of the plan (behov/kvalitetskrav, som ej tillgodoses).

These long-term plans contain a set of priorities within the health sector according to each type and level of care, e.g., district officers, long-term care facilities, and others. Priorities are given for time

periods of three to five years, with the manpower and capital investments required to meet those priorities per time period. These 3–5 year components of the long-term plans are the frame within which the medium-term plans are prepared.

Swedish long-term planning of manpower and resources by types and levels of care—primary, secondary, and tertiary—differs from most of the planning of the health departments in the United States, which is categorical by types of disease (e.g., venereal disease, tuberculosis control programs), by age or sex groups (e.g., maternal and child care services), or by income group.[35]

It is worth underlining that each of the described stages is developed by the planning staff with the participation of the different groups that usually are represented on the planning advisory groups. The majority are heads of hospital departments, mostly of teaching hospital departments, who enjoy great power and influence. The strengths and weaknesses of these planning advisory groups will be discussed in context in Chapters 4 and 5. The composition and structure of these groups are patterned on the types and levels of care corresponding to the proposed organizational structure of the health services (see Chapter 2 on medical blocks and organization of health services).

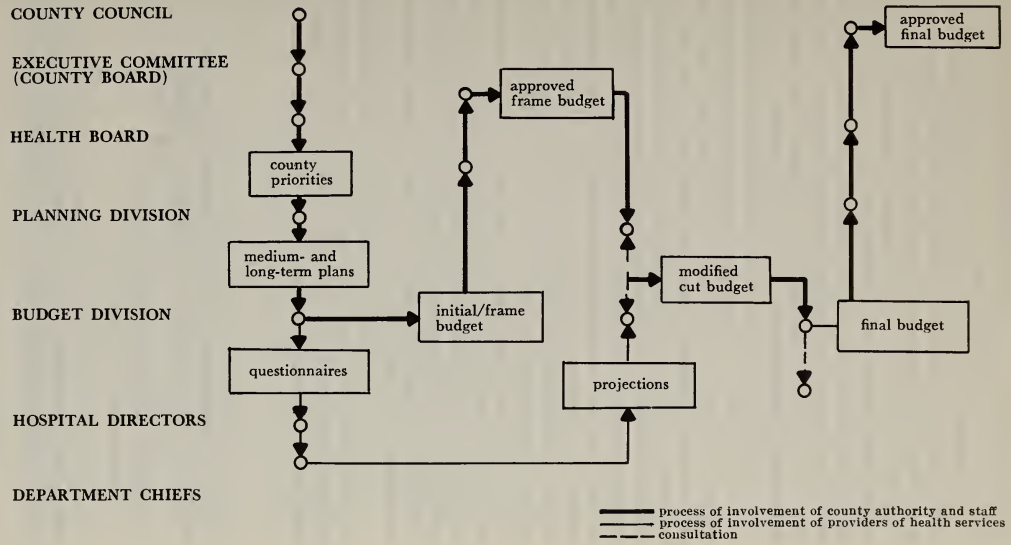
As mentioned before, the degree of development and sophistication of the planning process varies considerably from county to county, and it would be misleading to represent the model discussed as obtaining uniformly across the country. While it is quite advanced in some areas, as in the Göteborg Board, it is far from well developed in others. Actually, it is one of the aims and responsibilities of the National Institute for the Planning and Rationalization of Health and Social Welfare Services (SPRI) in Stockholm to encourage the development of this process, consulting and providing assistance to the county councils in the preparation of their long-term plans. The part on "Developments in Health Services Planning" in Chapter 4 describes the new proposals, prepared by SPRI and the National Board, for the preparation of the long, medium, and short-term plans by the county councils.

LONG-TERM BUDGETING AND ITS ADMINISTRATIVE RELATIONSHIP TO LONG-TERM PLANNING IN THE HEALTH SECTOR

As shown in Chapter 1, the political levels involved in planning and budgeting in the health services sector at the county commune level

[35] Oregon State Department of Health, *Comprehensive Health Plan for the State of Oregon.*

FIGURE 13. THE RELATIONSHIP BETWEEN THE PLANNING AND BUDGETING PROCESSES



are the county council, its executive committee, the county board, and within that board, the health board.

In accordance with the goals, objectives, and constraints set by these political bodies, the planning division prepares the long and medium-term plans. Based on the latter, the budget division prepares an initial long-term budget, where costs and services are initially allocated according to the priorities of the medium-term plan. This initial budget, referred to as the *frame budget* (see Figure 13), is sent to the political bodies for discussion and approval and, once approved, is referred to the planning division. Concurrently, the budget division sends a series of forms to the directors of hospitals and institutions, accompanied by a statement of priorities and an initial allocation of resources by sectors and institutions. These forms are itemized questionnaires asking for the 5-year projected plan of activities of the hospitals and departments and the resources required. The directors pass the forms to the chiefs of the departments for completion. Thus, first the chiefs of the departments, and second, the directors of the hospitals provide questionnaire information outlining their 5-year projections of required resources. Based on these projections, the budget division estimates the overall level of resource requirements. These are sent to the planning division, which then modifies the overall levels of requirements to match the requested resources from below with the resources of the frame budget that comes from the top. In this process of modifying and usually cutting, the planning and budgeting divisions seem to work very closely with the affected institutions, a process which is graphically represented by the broken lines in Figure 13. On the basis of these consultations, the budget division prepares the completed budget which is submitted to the political bodies for final discussion and approval.

As with long-term planning, the specifics of long-term budgeting and its relationship to long-term planning vary from county to county. The particular steps involved in the actual process of planning and budgeting in two specific cases—an urban and a rural region—will be presented in Chapters 4 and 5.

SECTORAL PLANNING: THE RELATIONSHIP BETWEEN HEALTH PLANNING AND SOCIOECONOMIC PLANNING

The Methodology of the Royal Commission on Regionalization of Health Services

Since the bulk of county council expenditures is for personal health services, the coordination between county commune, regional, and national planning involves primarily the coordination of county health

planning with regional and national planning considered in the first section of this chapter.

The following discussion addresses the specific methodology that health planning shares with socioeconomic planning at the regional level, as represented in the Royal Commission on Regionalization of Health Services discussed previously. Regarding the geographic regional distribution of health resources, two linked subjects are currently being debated in the literature on regional health planning, (1) the problem of balancing the geographic decentralization of resources generally motivated by public demand with the necessary centralization required to increase their efficient use; and (2) achieving this balance of decentralization and centralization of resources within the context of general socioeconomic regional development.

In the Royal Commission on Regionalization of Health Services, these two problems were presented to the planning team as "the task to throw light on the question of which towns these large regional hospitals should preferably be assigned to and how the whole of Sweden could best be divided into referral regions.[36] Operationally, the problem was to maximize accessibility, measured by the time spent in traveling to health facilities, for the largest possible number. Moreover, the services should be distributed according to the organizational model of regionalization defined above.

The constraints imposed on the possible solutions were that, due to the high costs involved, maximum advantage should be taken of existing facilities and that changes must be made in stages. Furthermore, four hours of traveling time, either by car or public transport (bus, train, or sometimes airplane) [37] were fixed as the maximum for a single journey to a regional hospital center, to enable patients to make hospital visits of a routine nature without having to stay overnight.

It was agreed that the minimum size of a region should be one million. (The rationale for this number has been explained previously in the third stage of long-term planning in the health sector.) Thus, using the projected population of eight million for 1970, the country was divided into eight health regions. It was further decided that each region should be served by a centrally located metropolitan hospital, thus narrowing the choice of regional centers among the eleven large cities of Sweden. The first constraint, however, i.e., that maximum advantage be taken of already existing facilities, limited the number of alternatives because five cities (Stockholm, Uppsala, Lund-Malmö,

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[36] A. Engel, *Regionsjukvarden*. Also see A. Engel, "Planning and Spontaneity in the Development of the Swedish Health System."

[37] Airplane traveling time was considered for populations living on islands off the mainland.

Göteborg, Umea) already containing six teaching hospitals were considered suitable for regional centers. Thus, the problem was reduced to selecting the two remaining regional centers, whose location could be chosen from among the other six cities.

The final decision regarding location of the regional hospital centers and the geographic size of the region was based on (1) the total demographic and socioeconomic development of Sweden and (2) the accessibility to the population of the alternative locations for regional hospitals.

Demographic and Socioeconomic Development

Table 16 shows a 1.1 million population growth from 1930 to 1955. The population forecast for the whole of Sweden gives a total population of about eight million in 1970 and 8.3 million in 1975, presenting an increase for the 20-year period 1956–1975 of nearly one million. Also, figures point to an increase in urban over rural population, which is assumed to be the result of a considerable increase in the population in large and medium-size towns and certain commercial and industrial centers, and a definitive decrease of population in the agrarian parts of the country. Table 17 displays observed and expected changes in different sectors of the labor force for the period 1930–1975 for the entire country.

This analysis of demographic and socioeconomic development was made for all counties in Sweden. The choice of the county council as the basic political unit to analyze and estimate these changes was made primarily because the Swedish hospital system is largely organized on a county council basis.

Table 16. TOTAL SWEDISH POPULATION BY URBAN AND RURAL AREAS IN THE PERIOD 1930–1975

End of year	Population (million)			Urban population* %
	Urban	Rural	Total	
1930	3.0	3.2	6.2	49
1940	3.6	2.8	6.4	56
1950	4.7	2.4	7.1	66
1955	5.0	2.3	7.3	69
1960	5.5	2.0	7.5	73
1970	6.1	1.9	8.0	76
1975	6.5	1.8	8.3	78

*Degree of urbanization.

Adapted from: V. Navarro, "Methodology on Regional Planning of Personal Health Services: A Case Study: Sweden," *Medical Care*, 8:386–394 (1970), 391.

The examination of occupation and employment trends at the county level was considered more reliable for estimating future population at these levels than solely demographic projections. According to this information, population density maps for the whole country were prepared for the period 1955–1975.

Accessibility of the Regional Centers

To calculate accessibility of the proposed regional centers to the current and projected population, estimates of traveling times for public transport and private car were made for the period 1955–1975. It was assumed that for short journeys patients would use cars, private or taxis, while public transport (buses, trains, and aircraft) would be used for longer trips. However, inventories were made for both types of transport, public and private, for both long and short distances.

In areas accessible to public transport, the inventory of traveling times by train and bus was made according to the shortest times scheduled for 1960. For those areas without public transport, estimates were made on the use of private cars or taxis.

The inventory of traveling times by private car was determined on the basis of the average speeds for each road category and 60 km per hour on public highways. In all cases, the road studied was the best and most direct round trip route between homes and the regional

Table 17. PERCENTAGE DISTRIBUTION OF THE NUMBER OF PERSONS EMPLOYED IN DIFFERENT PRODUCTION SECTORS IN SWEDEN 1930–1975

Production sector	Distribution of the number of employed persons %			
	1930	1940	1950	1975
I. Primary or means of production				
Agriculture	28	24	17	8
Forestry	3	3	2.5	3
Fishing	1	1	0.5	0.3
Mining, manufacturing	28	30	33	35
Building and civil engineering	6	6	8	8
II. Secondary or services				
Transport	6	7	8	7
Trade	12	14	16	22
Public service	7	9	11	15
Household work and other	9	7	4	2
Total	100	100	100	100

Adapted from: V. Navarro, "Methodology on Regional Planning of Personal Health Services: A Case Study: Sweden," *Medical Care*, 8:386–394 (1970), 393.

hospital center. In making these inventories, it was estimated that there would be one car per four to five persons in 1965 and one per every three in 1975, or practically one car per family.

The inventory of traveling times was then represented graphically on isochrone maps, which presented isochrones or lines joining points situated at the same traveling times from a given center. The interspace between two consecutive isochrones, called umlands, represented one hour's time. The isochrone maps for each alternative location were then superimposed on the population density maps for the years 1955–1975, thereby enabling the population in the various zones to be determined. The aggregate traveling times were calculated by multiplying the population densities of the umlands by the traveling times indicated by the isochrones.

The planner's task was to select the location which minimized traveling times for patients seeking care at the regional centers. In order to simplify the task and to obtain accurate comparisons among the various alternatives, the assumption was made that persons would visit the center with the same frequency regardless of sex, age, and occupation.

With each alternative, an attempt was made to ensure that the umlands or geographic extensions limited by isochrones and the remittal regions, comprised of county councils, would coincide as much as possible. For reasons of administrative and fiscal policy, it was considered desirable to constitute the remittal regions by combining whole counties. Thus, regional boundaries were adjusted to coincide with the nearest county boundary wherever possible. Only rarely was it deemed justifiable to divide a county between two regions.

Costs were also considered. Following a method similar to that used for traveling times, traveling costs were calculated for the alternative locations of the regional centers. Isodapan maps or maps with isodapan lines joining points situated at the same traveling costs from a given center were superimposed on population density maps and aggregate traveling costs were calculated.[38] The problem in both cases—time and costs—was one of optimization, subject to defined constraints, and the techniques used were those of mathematical programming.

Table 18 is a summary of regional divisions based on one alternative which had as its objective the delineation of regions through use of the present teaching hospitals as regional centers, without construction of new regional facilities. In the light of the previously defined prin-

[38] For a more detailed explanation of this method, see: S. Godlund, "Population, Regional Hospitals, Transport Facilities, and Regions," 6; and A. Engel, *Regionsjukvarden.*

Table 18. SUMMARY OF REGIONAL DIVISIONS ACCORDING TO ALTERNATIVE I

Region	Number of regional centers	Population of region (in thousands)	
		1955	1975
Stockholm	2	2164	2550
Uppsala	1	1324	1442
Lund-Malmö	1	1701	1792
Göteborg	1	1550	1725
Umea	1	551	605

I. Proportion of the population in 1955 within four hours' traveling time of the regional centers	
Public transport	76.1%
Private transport	76.7%
II. Total traveling time in 1955 in million hours	
Public transport	3.93
Private transport	3.72
III. Total traveling costs in 1955 in million kronor	
Public transport	21.41
Private transport	31.21

Adapted from: V. Navarro, "Methodology on Regional Planning of Personal Health Services: A Case Study: Sweden," *Medical Care*, 8:386–394 (1970), 393.

Table 19. SUMMARY OF REGIONAL DIVISIONS ACCORDING TO THE CHOSEN ALTERNATIVE

Region	Number of regional centers
Stockholm	2
Uppsala	1
Lund-Malmö	1
Göteborg	1
Umea	1
Linköping	1
Karlstad	1

I. Proportion of the population in 1955 within four hours' traveling time of the regional centers	
Public transport	84.4%
Private transport	87.3%
II. Total traveling time in 1955 in million hours	
Public transport	3.34
Private transport	2.99
III. Total traveling costs in 1955 in million kronor	
Public transport	18.22
Private transport	25.34

Adapted from: V. Navarro, "Methodology on Regional Planning of Personal Health Services: A Case Study: Sweden," *Medical Care*, 8:386–394 (1970), 391.

ciples, planners considered this alternative unsuitable due to population figures per region which were higher than the desired one million, especially for the Lund, Malmö, and Göteborg regions, as well as to the high aggregate traveling times and costs.

Table 19 shows the alternative chosen. It provides for regional centers in six already existing teaching hospitals in five cities, plus two regional hospital centers to be located in the cities of Linköping and Karlstad. This alternative was chosen because it was the one which maximized the percentage of population living in umlands within four hours' time from the regional centers and minimized the aggregate traveling times and costs for the total population of Sweden for the years 1955–1975.

ANTICYCLICAL PLANNING

In anticyclical planning, as we have mentioned in the previous section, in regions with high unemployment the National Labor Board allows special construction of health facilities previously approved by the National Board of Health, with the primary objective of providing public employment. Actually, the construction of health facilities constitutes a considerable percentage of the government's public employment policies. In this respect, the health services sector does participate in the anticyclical planning, through the special construction program. To this effect, the National Board of Health maintains a list of projects whose priority for implementation depends on overall national manpower planning.

Chapter 4

NATIONAL HEALTH PLANNING

NATIONAL GOVERNMENT LEVEL

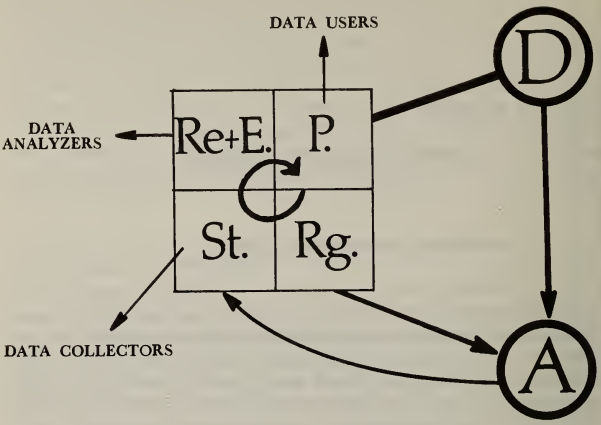
Planning is one of the most ambiguous terms in contemporary socioeconomic literature, and unless its meaning is defined, the use of this term can be more confusing than helpful. The need for definitions is particularly urgent in the present debate in the United States on the restructuring of the health services, in which planning, regulating, and decision making are frequently used interchangeably, and in which regulating agencies, for instance, are often referred to as planning agencies, and vice versa.

As indicated in Chapter 1, according to this author, planning is only part of the decision making process, which includes different stages: choosing the goals and objectives of the plans, selecting the alternatives to be implemented, and effecting their actual implementation. Although these stages are dependent and interrelated, they have to be considered separately for analysis purposes, as they serve different functions and are carried out by different groups (see Figure 14).

The *decision makers* are those who decide on the goals, objectives, and final plans to be implemented. Additionally, they determine the political and economic constraints and reference points within which the planners formulate the plans. In other words, the decision makers are those in the decision making process who have the first and last word on all policy decisions.

The *planners* are the groups within the decision making process which prepare the actual plans. They define the concrete objectives and alternative means of reaching them from which the decision makers will choose, and, moreover, they make explicit the consequences of choosing a given alternative. The planners have to work very closely with the group of decision makers, establishing a two-way flow of information, i.e., of policy from the decision makers to the planners,

FIGURE 14. REQUIRED FUNCTIONS AND GROUPS IN THE DECISION MAKING PROCESS



D Decision Makers
P Planners
Rg Regulators
A Administrators
St Statistical Groups
Re+E Research and Evaluation

and of primarily technical information from the planners to the decision makers. In this manner, the planning groups develop the long-term 15 to 20-year plans, medium-term 5 to 10-year plans, and short-term 1 to 3-year plans. Among the planning groups, the one developing the short-term plans must be very close to the next group in the process, the regulators.

The *regulators* assure the implementation of the final plan by the executors or administrators, checking its implementation against the norms, standards, and indicators generated and defined by the plan by means of several tools, of which one of the most powerful is, of course, budgeting. It is worth underlining that administrative experience suggests that unless the regulators receive and follow norms and standards established by the long, medium, and primarily the short-term plans, they tend to develop their own criteria, their own norms and standards, in summary, their own plan. This tendency, which develops quite frequently when the regulation group is administratively independent from the planning groups, may make the work of the latter irrelevant,

because, in effect, the plan implemented will be the one developed by the regulators. This problem has elicited the suggestion that the regulators should regulate the implementation of the plan not separately, but as developed by the planning groups.

The *administrators* are the executors of the policies and plans chosen by the decision making group. Their implementation and execution of the plan generates information for the group of data collectors.

The *data collectors* assemble the information generated in the process of plan implementation, collecting and processing such data as are relevant to the planning, evaluation, regulation, and administration of the system. These data, which can be collected either on a continuous or a sporadic basis, are analyzed by the research and development groups.

The *data analyzers,* or *research and development* groups, fulfill different functions: evaluation or analysis of the degree to which alternatives chosen in the plan and executed by the administrators have achieved the desired objectives, and estimates of the effect of the various components of the plan on those objectives; applied research in specific areas that may be relevant to the preparation of the plan (e.g., research on the feasibility and advisability of developing new types of personnel); and development, as an activity different from applied research and aimed at stimulating the development of new policies (e.g., the development of new types of personnel), the feasibility and advisability of which have been established in the applied research stage. In a large organization, these three different tasks become specialized and are performed by different subgroups within the overall research and development group. Finally, the information analyzed by the research and development groups is used by the planning group to prepare the alternative plans from which the decision makers will choose.

To recapitulate, according to the flow of information, the major groups in the decision making process can be characterized as data collectors, data analyzers, and data users—the latter including the planners, the regulators, the administrators, and the decision makers.

Obviously, the different functions assumed by these groups are not as clear cut and well defined in practice as outlined in the preceding. The planners, for instance, since they channel the information to the decision makers, have considerable influence and control in the decision making process and thus share some of the decision making power with the decision makers.[1] Thus, these categorizations have to be taken

[1] The final word is that of the decision maker, however, and this justifies the somewhat arbitrary classification.

as points of reference only and not as rigid boxes or compartments. The value of the model is as a framework for the analysis of the tasks of the different groups. In this respect, the functions and their relationships are more important than the specific groups that embody them.

A last point worth underlining is the sound administrative practice of reserving skepticism about names, terms, and titles of agencies and groups, and appraising them more on the basis of what they do rather than what they say. This afterword is particularly relevant in the field of planning. Indeed,

> . . . the generally held misconception that planning is used to produce a report or document—the plan—has led to the reverse fallacy that because certain groups did not have a document or report, they were not engaged in planning, and thus the resulting change (or lack of it) was unplanned.[2]

Having thus defined, with a note of caution, the groups within the decision making process, we may examine how these groups are represented in the decision making process at the national level within the Swedish health services.

THE DECISION MAKERS

As defined in Chapter 1, the formal decision makers at the national level in the health sector are the Cabinet and the Parliament, with its Standing Committees. Of these, the Standing Committee on Social Affairs is the most important in matters of regulation, control, and organization of health services, while the Standing Committees on Finance and on Taxation are the most important in matters of taxation and funding of health services. Other Standing Committees, of course, are also relevant and of interest in the planning of health services, such as the Standing Committee on Physical Planning and Local Government (which controls the physical location of facilities), or the Standing Committee on Labor and Housing (which controls regional development and manpower distribution).[3]

In addition to these political bodies, there are other institutions at the national level that have great influence in the field of health services. Of major importance is the National Federation of County Communes described in Chapter 1. Indeed, because most of the health

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[2] V. Navarro, "The City and the Region; A Critical Relationship in the Distribution of Health Resources," 882.

[3] See Chapter 1 for a more detailed description of these committees and their responsibilities.

services are run by the county communes, this body has a very strong influence on decisions at the national level regarding the planning, funding, and general operation of personal health services.[4]

THE PLANNERS

The Ministries take first place among the planning groups at the national level, designing the goals, objectives, and alternative plans from which the decision makers, the Cabinet and Parliament, will choose. As indicated in the first chapter, these Ministries resemble the White House staff and the staffs of the Department Secretaries of the federal government in the United States. The Ministry staff is mostly young, people in their 30's or early 40's, and lawyers predominate (except in the Ministry of Finance, where there is a predominance of economists and public administrators). They provide the political alternatives and background information required for Cabinet decisions. Again, not unlike the United States, the Ministries have increasingly centralized the task of policy planning, and are now less willing to delegate this task either to the Royal Commissions, which used to be, and to a degree still are, the bodies officially in charge of preparing policy alternatives and recommendations to the Cabinet, or to the agencies, which have always had broad leverage in interpreting both policy and legislation.[5]

The Ministry of Health and Social Affairs is the most important Ministry in policy planning in the field of health services at the national level. Supporting the Ministries in their policy planning are the agencies; specifically, in the field of health, the National Board of Health. (See Chapter 1 for a detailed description of the functions, responsibilities, and structure of the Ministry and the Board of Health.) Within the Board, two departments are of great importance in the process of preparing the alternative plans to be submitted to the Ministries and to the political bodies: the Department of Health Care and the Department of Planning.

Apart from the Ministries and agencies, there exist several national

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[4] The equivalent federation for the municipalities, the National Federation of Municipalities, plays an active role in the planning of social personal services and environmental health services at the national level, but a very limited one in the planning of personal health services.

[5] See Chapter 1 for a detailed description and appraisal of the changing distribution of functions among Ministries, Agencies, and Royal Commissions. Worth underlining is that the Swedish Royal Commissions are more truly policy planners than the Presidential Commissions in the United States. Actually, the latter have the function of generating a public mood, while the Royal Commissions have the function of generating alternatives for direct translation into policy.

councils such as the Economic Planning Council, the Regional Development Council, and the National Health Planning Council, which cross ministerial lines and serve to coordinate policy and the plans prepared primarily by the Ministries in their formulation as well as in their implementation.

The National Health Planning Council is chaired by the Undersecretary of the Ministry of Health and Social Affairs. Its members are the Undersecretaries of the Cabinet office and of the Ministries of Finance, Education, Interior, and Physical Planning and Local Government. It also includes the Directors General of the National Boards of Health, Education, and Labor, and representatives of the National Federations of County Communes and Primary Communes. Civil servants from the National Board of Health act as staff to the council.

Besides coordinating policy planning for the health sector, the National Health Planning Council establishes the national priorities for the allocation of capital investment and manpower resources to the health sector. These priorities are initially analyzed, prepared, and submitted to the Council by the Ministry of Health and the National Board of Health. After discussion and approval by the Council, priorities are submitted, first to the Cabinet and then to Parliament, for annual approval. In 1971, for example, the priorities for capital investment were: first, ambulatory care; second, long-term facilities; third, psychiatric services; and fourth, acute somatic hospital services. In terms of manpower, the priorities were to fill already existent vacancies; to create new positions in ambulatory, psychiatric, and long-term care; and to develop new openings in postgraduate education, in that order. Once approved by Parliament, these priorities are used as guidelines by the state health planning and regulating bodies.[6]

Besides the National Health Planning Council, a Committee for Comprehensive Health Planning at the central government level was created in 1971. Its functions and responsibilities include (1) coordination of health planning with socioeconomic planning, particularly in the long-term plans, in collaboration with the National Federation of County Communes and the National Institute for the Planning and Rationalization of Health and Social Welfare Services (SPRI); (2) development of specific norms and standards to serve as guidelines for manpower and facility planning in the health sector within the priorities set by the National Health Planning Council; and (3) encourage-

[6] These priorities, although considered national priorities at the central government level, are usually also chosen by the county councils as priorities at the local level.

ment of the preparation of long and medium-term plans by the county councils.

The Committee for Comprehensive Health Planning is chaired by the head of the Department of Planning of the National Board of Health and includes the head of the Secretariat for Economic Planning of the Ministry of Finance, two members from SPRI, two members from the National Federation of County Councils, one member from the Secretariat on Regional Development of the Ministry of Labor and Housing, and two staff members from the National Board of Health. It reports to the National Health Planning Council and has as its staff eight civil servants from the National Board of Health.

The rationale for the creation of this Committee was complex but it would seem that primary factors determining its establishment included a national concern for the increased costs of medical care, and the felt need for stimulating planning at different levels of government and for providing a framework and conceptual model within which the planning and regulating activities of the state could take place. Actually, it was felt that the priorities established by the National Health Planning Council had to be considered within a national health planning process aimed at producing, at a later date, a national health plan that would be part of the overall national long-term plans. In this respect, the function of the Committee seems to be to operationalize these priorities through the planning and regulating activities of the state in the health sector. State planning and regulating activities are dual: on the one hand they are advisory, providing the guidelines within which the long and medium-term plans are prepared at the local level, and on the other hand they are compulsory, effected through different regulating processes and activities, such as the requirement for the county councils that capital investments and new manpower priorities be approved by several state agencies.

The Preparation of Norms and Standards

Manpower

A key question in the planning process of course, is how the norms and standards used are estimated for manpower and facility planning in the health sector at the state level, and by whom.

Regarding manpower planning, the manpower division of the Department of Planning of the National Board of Health prepares the long and medium-term projections and plans for the different types of personnel required in the health sector. These plans

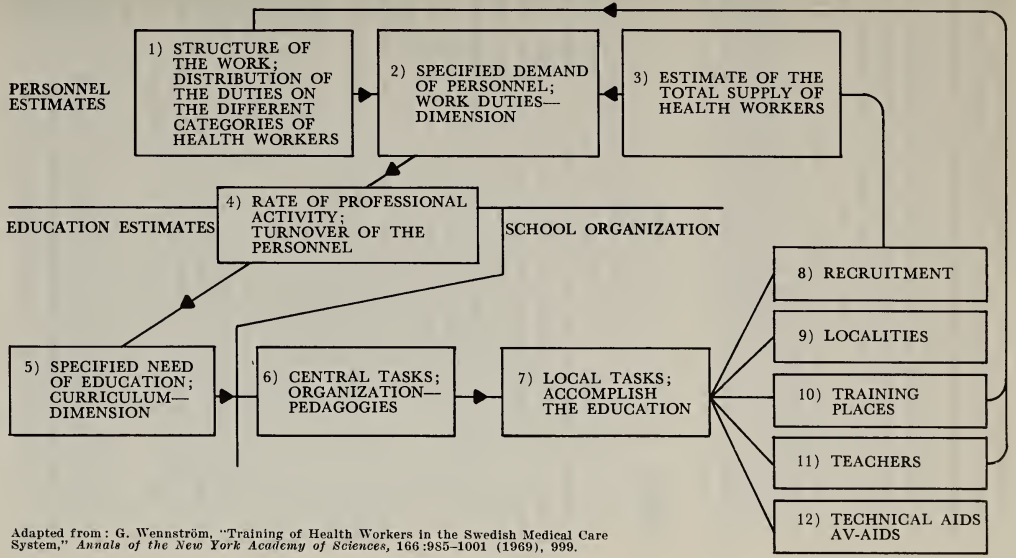
are prepared following a supply-demand model. Indeed, the present and projected demand for different types of personnel is generated by the county commune authorities and depends not only on the structure of the health services within each county (a structure that is far from uniform) but also on the distribution of activities of the different categories of personnel. This present and projected demand is recorded, in the Board's division of manpower, by the survey known as the RUPRO 5-year progressions which will be discussed in the context of data collection.

The supply side of the model is estimated according to the projected output from the teaching institutions and medical schools. In this connection, it is worth underlining that the total number of physicians produced by the medical schools is regulated and controlled by the Commission on Postgraduate Medical Training, a paragovernmental body with representatives from the academic institutions, medical schools, and the state and local authorities. This commission establishes, for instance, the number of openings for internship and residencies that will be available every year, according to the capacity of the educational system as well as according to the national priorities established by the National Health Planning Council. The present and projected capacity of the educational system is calculated by the manpower division of the Planning Department of the National Board of Health. It works directly with the Commission on Postgraduate Medical Training. Their conjoint estimates are based on specific needs for types of curriculum, according to desired tasks to be performed, the resources available to the educational system (such as teachers, equipment, and locales), and the pool of applicants and the recruitment to the educational system. Figure 15 outlines the different steps followed in the supply-demand model used to estimate the required norms and standards of personnel.

Because demand always tends to be larger than supply, the allocation of manpower in terms of approval for new positions, particularly physicians and nurses, is done at the central government level in accordance both with state priorities designed by the National Health Planning Council, and with long-term plans prepared by the division of manpower of the Department of Planning of the National Board.

To this observer, this structure, which works rather well in controlling the "production of specialties within the medical profession," provides a forum for active collaboration and cooperation by the different pressure groups influencing the production of physicians, i.e., medical schools, academic institutions, and state and local authorities. The somewhat greater influence of the former, particularly

FIGURE 15. PERSONNEL AND EDUCATION PLANNING IN HEALTH AND MEDICAL CARE


PERSONNEL ESTIMATES
1) STRUCTURE OF THE WORK; DISTRIBUTION OF THE DUTIES ON THE DIFFERENT CATEGORIES OF HEALTH WORKERS
2) SPECIFIED DEMAND OF PERSONNEL; WORK DUTIES— DIMENSION
3) ESTIMATE OF THE TOTAL SUPPLY OF HEALTH WORKERS
EDUCATION ESTIMATES
4) RATE OF PROFESSIONAL ACTIVITY; TURNOVER OF THE PERSONNEL
SCHOOL ORGANIZATION
5) SPECIFIED NEED OF EDUCATION; CURRICULUM— DIMENSION
6) CENTRAL TASKS; ORGANIZATION— PEDAGOGIES
7) LOCAL TASKS; ACCOMPLISH THE EDUCATION
8) RECRUITMENT
9) LOCALITIES
10) TRAINING PLACES
11) TEACHERS
12) TECHNICAL AIDS AV-AIDS

Adapted from: G. Wennström, "Training of Health Workers in the Swedish Medical Care System," *Annals of the New York Academy of Sciences*, 166:985–1001 (1969), 999.

noticeable in the Commission on Postgraduate Medical Training, may explain the skewed distribution of specialties within the medical profession, with heavier weighting for secondary and tertiary specialties over the primary ones. This unbalanced production of specialties is now being corrected as a result of the priority which the National Health Planning Council has recently given to ambulatory care.

This change of priorities from the hospital to ambulatory care is due in great part to concern with costs by the state and local authorities, operating on the assumption that ambulatory care is less expensive than hospital care.

Also worth underlining is that the described structure controls the production but not the geographical distribution of physicians. This distribution is regulated, as will be shown later, by the National Board of Health.

Facilities

The norms and standards for facilities planning are prepared by the division of hospital and institutional care within the Department of Health Care of the National Board of Health. It is worth underlining that this department, as will be described later, is not limited to facilities planning, but also acts as the regulatory body for facilities and manpower, as will be discussed further down. It would seem that this separate responsibility for manpower and facilities planning in two different departments is not conducive to the coordinated and integrated planning of these two sectors. As to the establishment of norms for facilities planning, there has been continual evolution in the definition of norms and standards for required facilities, parallel to the change and evolution in the concept and application of regionalization in Sweden.

The concept of regionalization was first accepted in Sweden in 1958, when Parliament approved the recommendations of the Royal Commission on Regionalization of Health Services, also referred to as the Engel Report, because Dr. A. Engel, then Director General of the National Board of Health, was the only member of that Royal Commission. The report divided hospital services in Sweden into eight regions, primarily for the planning of the tertiary or superspecialty services, and, as described in detail in Chapter 3, the optimum size of the population to be served in each region was determined by ascertaining the minimum number of persons needed to support the teaching, research, and service activities of the superspecialized departments (neurosurgery, plastic surgery, thoracic surgery, pediatric surgery, special cardiology) to be centralized at the

regional hospital center.[7] Following the methods described in the section on long-term planning in the health sector in Chapter 3, it was suggested that these tertiary services be grouped in regional centers serving a population of over one million.[8]

As to the secondary or specialty services, Engel suggested that each community hospital should serve a population base of approximately 250,000 persons. The following services were to be provided in each hospital:

> . . . internal medicine, general surgery. pediatrics, gynecology and obstetrics (women's clinic), ear, nose and throat, ophthalmology, neurology (in larger counties only), dermatology (in larger counties only), orthopedics, minor psychiatry, rehabilitation clinic, long-term diseases.
>
> Other services: radiology, anesthesiology, physiology, biochemistry, microbiology, pathological anatomy, dental clinic.[9]

Following this model of regionalization, the norms for ratios of beds to population were established. Table 20 shows the ratios of beds to population for some of these specialties.

These norms based on bed/population ratios were used as criteria for the planning of facilities. Indeed, until recently, when the county communes asked for permission from the state agencies to make a capital investment in the hospital sector, approval was based on the established norms, defined by the above-mentioned division of hospital and institutional care of the National Board, and according to the national priorities established by the National Health Planning Council.

This system of planning according to overall bed/population ratios, however, has proven somewhat unsatisfactory in the last 15 years; since 1971, and with the creation of the Committee for Comprehensive Health Planning, the approach in planning has been toward the development of a regional conceptual model, not only for hospitals, but for all levels of care, to include not only manpower but also facilities requirements. Following this model, the requirements are defined not according to the size of the population required for certain services, but vice versa, according to the types of services required for different population sizes: from 0 to 10,000; from 20,000 ot 100,000; and

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[7] A. Engel, *Regionsjukvarden.*

[8] For the methodology followed in defining the geographic size of each health region, see V. Navarro, "Methodology on Regional Planning of Personal Health Services: A Case Study: Sweden;" S. Godlund, "Population, Regional Hospitals, Transport Facilities, and Regions;" and A. Engel, op. cit.

[9] A. Engel, *The Swedish Regionalized Hospital System,* 5–6.

Table 20. HOSPITAL BED TO POPULATION RATIOS FOR VARIOUS MEDICAL CATEGORIES AS RECOMMENDED BY THE SWEDISH NATIONAL BOARD OF HEALTH

Hospital category	Beds per 1000 population
Nonspecialized (residual small hospitals)	0.2
Surgery	1.3–1.4
General medicine	1.4–1.5
Gynecology	0.3–0.4
Obstetrics	0.5
Otorhinolaryngology	0.15–0.19
Ophthalmology	0.12
Pediatrics	0.3
Orthopedics	0.3–0.4
Long-term care (in nursing homes)	(3.75)
Lung diseases (decreasing)	0.4
Contagious diseases (decreasing)	0.2–0.3
Psychiatry (minor)	0.3
All categories	5.72–6.26

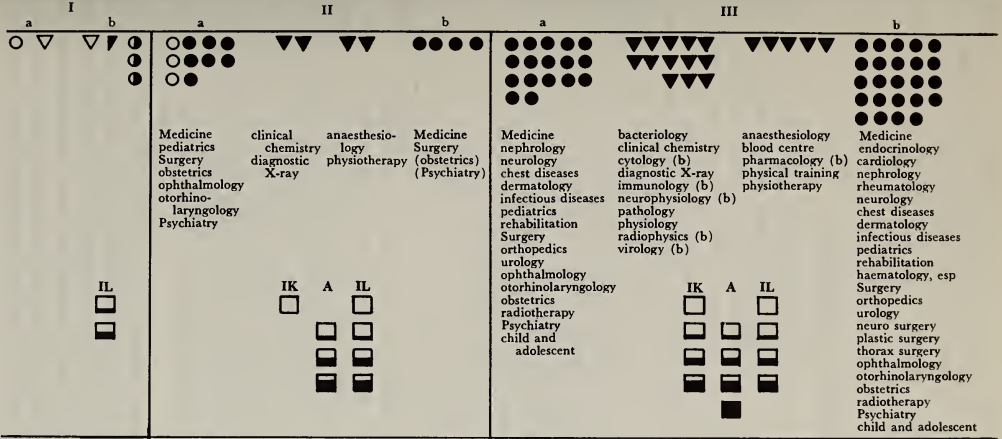
Adapted from: A. Engel, *The Swedish Regionalized Hospital System* (Stockholm: National Board of Health, 1967), 4.

from 250,000 to 1–1, 500,000, with different types of personnel and facilities required for each community size (see Figure 16).

Parallel to this change, there has been a significant change in the requirements and expectations of state planning bodies concerning the plans prepared at the local level. Indeed, the county communes have been encouraged since 1971 to present their demands as part of long and medium-term plans. For instance, the approval of specific items, such as new physician positions, would depend on the relationship of that item to the overall long and medium-term plans for health services of that county. It is the function and responsibility of the Comprehensive Health Planning Committee and SPRI to stimulate and assist the county councils in preparing such plans.

The first change in the establishment of norms, from using overall bed/population ratios to the establishment of services required for different population sizes, was mainly due to a desire by the state authorities, particularly the Committee for Comprehensive Health Planning and the Federation of County Councils, to stimulate the regionalization of health services, establishing service areas for different types of facilities. The second change, the suggestion by the Committee for Comprehensive Health Planning and the Federation of County Councils that the county councils present their annual re-

FIGURE 16. FACILITIES AND MANPOWER REQUIRED FOR DIFFERENT LEVELS OF CARE



From: S. A. Lindgren, *Health Services in Sweden—Planning and Implementation* (Stockholm: National Board of Health, 1970), 24.

quests as part of medium and long-term planning, was intended to stimulate health planning and its cooperation with economic planning as represented in the national long and medium-term plans.

Both changes were instituted in 1972, and are thus too recent to permit evaluation.

THE REGULATORS AND CONTROLLERS

One of the most common misapprehensions in the current debate on planning in the United States stems from confusing the concepts of planning and regulation, that is, from using these terms almost interchangeably. Experience shows, however, the necessity of a clear distinction between the activities of planning and regulation. As pointed out before, the responsibility of the planning group is the preparation of alternative plans from which the decision makers will choose, and once the latter have chosen the plan(s) prepared by the former, plan implementation is carried out by the administration. Checking, supervising, and overviewing this administrative implementation are the regulators or controllers, who regulate the application of the plan according to the norms and standards defined by the planning group. Indeed, supervision and/or control of the application of the plan requires that the regulators be dependent, at least administratively, on the planning group.

As indicated earlier, it is this observer's experience that when the regulating groups are functionally and administratively independent of the planning group, they tend almost automatically to develop their own norms and standards. In short, they develop a plan of their own quite distinct from the plan prepared by the planning group. An example of this is the proposed hospital cost control commissions established at the state level in several states in the United States, which are supposed to regulate hospital costs. In those states where they are independent of the Comprehensive Health Planning Agencies, the commissions tend to develop their own criteria, making the work of the planning agencies, at least in this respect, largely irrelevant.

In this observer's opinion, the strength of the planning process depends both on the degree of controlling power given to the regulatory agency and on the degree of dependence of the regulatory agency on the planning agency. Indeed, the disenchantment with voluntarism of the present planning movement in the health sector in the United States is partly a result of its awareness of the old principle

in planning that $P_e - P_o = 0$, i.e., planning (P_e) without power (P_o) equals zero.

The truth of this principle does not imply, however, that the planning agencies themselves should become regulatory agencies. The former should guide the latter, but they are not the same. Unfortunately, however, this distinction is not always made, and experience shows that when the functions of both planning and regulation are carried out by the same group, practically all activity is directed toward regulation without much time (or energy) being invested in planning. The planning agency becomes the regulating agency, responsive only to crisis situations, and planning diminishes to problem solving. The planning group becomes the "crisis staff" of the operating agency.

In view of this distinction between the planning and the regulating activities, the next question is how the state in Sweden, in fact, regulates the implementation of the plan.

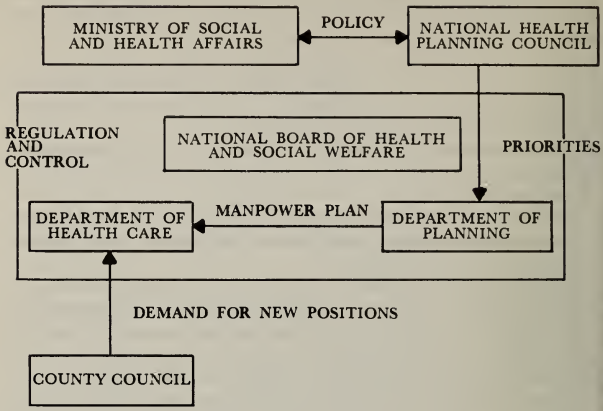
As indicated in Chapter 2, most of the personal health services in Sweden are owned, funded, and administered by the county councils. The councils take a great deal of pride in this situation, given that the running of health services is the main county council activity. Still, despite this local feeling and despite the great independence of the counties in this area, the state has subtle (and not so subtle) ways to regulate, guide, and control the overall development of health services at the county level.

Manpower Regulation

All new budgeted positions, not only for hospital-based physicians (generalists as well as specialists), but also for generalists and, as of 1973, for specialists working in ambulatory care for the local authorities, have to be approved by the Department of Health Care of the National Board of Health, according to priorities established by the National Health Planning Council and contained in the long and medium-term plans prepared by the division of manpower of the Department of Planning of the Board. Figure 17 shows the flow of manpower demand, as well as the planning and regulation of the supply of manpower.

However, the ability to influence the development of health services at the local level of this regulatory mechanism has two great limitations. First, only new positions require the approval of the state; the state cannot delete an already accepted and established position. Thus, efforts to reduce the number of physicians in oversupplied areas are seriously limited. Second, the state cannot initiate

FIGURE 17. THE HEALTH MANPOWER PLANNING AND REGULATION PROCESS IN SWEDEN



the establishment of a new position in undersupplied areas. In the words of a state health planner, "initiative is always in the county council and the state only responds."

Capital Investment Regulation

Every capital investment of the county council greater than 300,000 kronor, within or outside the health sector, has to be approved by the Labor Market Board and the Ministry of Finance. Indeed, as indicated previously, the Labor Market Board plays a key role in anticyclical planning by regulating the investments and the nature and type of construction labor in different areas and regions of the country. To decide what projects in the health sector are to be approved and where, the Labor Market Board usually follows the priorities established by the National Health Planning Council and the long and short-term plans prepared by the Department of Health Care of the National Board of Health. The number of projects and investments that can be approved by the Labor Board is prescribed by the Ministry of Finance.

Thus, it is actually the Ministry of Finance which establishes the

limits for capital investment in each economic and social sector. For the health sector, the National Board of Health receives a limited figure of allowable investments, within which both the Labor Board and the Board of Health exercise their regulation of investments. In times of increasing unemployment, this amount of allowable investments for public works, such as hospitals, increases to provide employment in the public sector.

Control of investments is one of the powerful tools that the state has to guide the development of health services at the local level. Similar to manpower regulation, however, the state cannot close down already existing facilities in overserved areas, nor can it stimulate investments in underserved areas.[10]

Design and Hospital Construction Regulation

The design of the hospital has to meet the standards and the approval of a special national committee, which includes a member representing the National Board of Health (the head of the Department of Health Care), a member of SPRI, a member of the National Federation of County Councils, and a medical professor as chairman.

THE DATA COLLECTORS

Who collects what data in the Swedish health services for planning purposes at the national level. Where and how are such data collected?

The National Center for Statistics, an independent agency within the state government, collects information on the vital statistics of the country. The division of statistics of the Department of Planning of the National Board of Health collects information, either annually or periodically, on:

1. The medical manpower registry;
2. Ambulatory care by ambulatory physicians, either private or public;
3. The 5-year projections or RUPRO; and
4. The hospital discharge survey.

[10] A further weakness is that the allowable investment criteria are limited only to the first year of investment. Subsequent years are not subject to the control or approval of the Ministry of Finance.

Medical Manpower Registry

By law, every physician, nurse, and midwife as well as other professionals and paraprofessionals have to report annually their address and specialty. For this purpose, a central manpower registry is kept in this division. Also, twice a year hospitals and facilities report to this central registry on their manpower situation, with information on vacancies, retirement, etc.

Ambulatory Care Registry

This registry covers only the public sector. The personnel at the professional and paraprofessional level working in the public sector have to report annually the number of visits (by type of visit—first and followup visit) and the estimated percentage of their time spent in providing care, administering, and undertaking research or teaching during the year. It is this observer's impression, however, that these estimates are very rough and subjective, recording the person's own impressions of how he used his professional time.

It is also worth underlining that this reporting by the ambulatory physicians in the public sector to the National Board of Health is a reporting per annum of overall number of services (i.e., visits) which does not include the number of persons seen. This latter information is collected not by the National Board of Health but by the local insurance fund, which records number of visits per insured person, and type of visit, according to the three categories of visits referred to in Chapter 2.

Five-Year Projections or RUPRO (Running Progressions)

These projections are surveys of the present and projected health services activities of the county communes, administered every 5 years. The first one was undertaken in 1967 and covered the period 1968–1973 (RUPRO 67). Pursuant to that survey, the county councils were requested to complete a questionnaire that included a survey of the activities and physical and manpower resources of the counties and their estimated annual projections of activities and resources for the period 1968–1973.[11] RUPRO is realized by a questionnaire containing several forms, with explanatory texts used to standardize terms

[11] Subsequent five-year surveys have been made: RUPRO 69, for the period 1970–1975; and RUPRO 71 for the period 1972–1977.

and concepts, thus making it possible not only to compare institutions and counties, but also to add up the services to a total for the whole country and to follow the trends of this total over a span of time. The questions asked in these forms aim at establishing the following information for each county:

Form 1: For each health facility, the number of present admissions and patient days, and present and estimated number of beds for the five-year period, for acute hospital care, by specialty, up to a total of 34 specialties;
Form 2: For each institution, the number of present admissions and patient days, and present and estimated number of beds for the five-year period, for all types of hospital and institutional care other than acute hospital care;
Form 3: For each institution, the present and estimated number of visits to physicians in outpatient clinics, by specialty.
Form 4: The number of visits to the district physicians, excluding some preventive activities such as school health services or outpatient health supervision;
Form 5: The present and estimated number of physicians required per type of care (ambulatory or institutional) by specialty and by position (senior, junior, assistant, and the like). In each manpower category, and for each year, information has to be provided by the county to the National Board on estimated filled and open positions, as well as on estimated changes in working hours for each category. For those counties with teaching institutions, a special form is provided to estimate the positions and working times for teaching.
Form 6: Similar to Form 5, but for all professionals and paraprofessionals other than physicians;
Form 7: The present and estimated production of paramedical personnel by the different health teaching institutions such as the nursing schools run by some county communes;[12]
Form 8: Present and estimated capital and operating costs for each institution in each county. Operating costs are detailed on wages and remuneration, rents, interest, goods, drugs, and services. Wages, the larger part of these costs, are divided into primary wages, which includes all wage costs, and secondary wages, which includes fringe benefits such as insurance premiums and pensions;
Form 9: The degree of intercounty relationships. The main items in this form deal with the present and estimated use by the county of the tertiary care services—the superspecialties—shared on a regional basis by various county communes. But it also includes the present and projected use by each county of facilities and services located in other counties.

This 5-year survey allows the National Board of Health to get an overall view of the health sector and to detect possible conflicts and bottlenecks that would hardly be evident at one point of time

[12] All training of paraprofessionals, except physical therapists, is done by the local authorities. Physicans and physical therapists are trained in state teaching institutions.

or just from the local level. The survey with 5-year projections has the additional advantage of allowing planners at the national level to determine to what degree their guidelines are being followed by the county councils. The National Board of Health may therefore define the areas of need in the light of the national priorities agreed upon by the National Health Planning Council, and act accordingly (within the limits defined in the previous sections). For example, according to the RUPRO–1967, the demand for personnel in long-term care and psychiatry by the county councils for the period 1968–1973 was lower than the state planning agencies considered advisable, while the demand for hospital based specialists for the same period of time was much larger than the state agencies felt necessary or than the supply of those specialists would allow. Thus, the granting of new posts regulated by the National Board of Health took that situation into account.

In summary, then, RUPRO is a survey of "heads and services" that to a certain degree allows the planners to determine the efficiency of the services. However, RUPRO is a facility centered survey, with all the strengths and weaknesses that this implies. The strengths are the advantages described in the previous paragraphs. Among the weaknesses, perhaps the most important is that the numerator data cannot be related to the denominator. Indeed, although information is collected about number of services provided by number of physicians, for example, RUPRO does not relate these services to people. In other words, the production units are services and not persons. RUPRO does not allow for the calculation of percentages of the population who actually use services.[13]

It is worth underlining that the data gathering system, with each patient retaining the same number regardless of the sector within the health services that he uses (that is, hospital, ambulatory or other types of care), would allow the tabulation of data not only by aggregate number of services but also by number of people generating these services. Cost as well as conceptual considerations, however, seem to have limited this alternative.

Hospital Discharge Survey

Independently of RUPRO, each hospital, on a voluntary basis, fills out a form for each discharge (see Figure 18). This discharge survey,

[13] When information of this nature is required, as in the preparation of the regional plan for Skane, special surveys have to be carried out to complement the information gathered by RUPRO.

based on a discharge record, includes information on civil, demographic, and utilization characteristics of the discharged patient and diagnostic and therapeutic information. A similar form is also filled out for deliveries. These forms are sent to the division of statistics of the Planning Department. Figure 19 shows the detailed instructions for filling out these forms. Also, Figure 20 shows the automatic data processing of the hospital discharge form, with the regular reports and tables published by the division of statistics (column NBHW of the form), which are sent back to the hospital departments (first column of the form). This survey is a voluntary one, and while in some counties, e.g., Uppsala, all hospitals participate in the survey, others have a lesser participation. It is estimated that 65% of all hospitals in Sweden contribute to this survey.[14]

In addition to the hospital discharge survey, each hospital produces an annual report, which it sends to the county councils as well as to the division of statistics of the National Board of Health, including numbers of visits and admissions, occupancy rates, and aggregate costs for services and departments. This report is also sent to the local insurance fund, because that fund pays 31 kronor for each discharge (see Chapter 2). Figure 21 summarizes the different types of data generated from the local level to the state level.

THE DATA ANALYZERS: RESEARCH AND DEVELOPMENT

Once again, in an area pregnant with value judgments and ideologies, there is a need to clarify the terms used. The first activity, research, entails an intellectual exercise conducive to the discovery of new knowledge. One example of research in health services is the study and analysis of the tasks that a nurse can take over from the physician. The other activity, development, entails the use of this knowledge by applying it to the solution of specific problems. For instance, following up on the previous example, research might show that a nurse could assume over 40% of the ambulatory tasks of a general practitioner; development, then, would involve programmatic translation of this finding to design the appropriate educational and medical care settings making effective use of that knowledge for better deployment of physician and nursing personnel.[15] Thus, these

[14] Personal communication, Department of Social Medicine, Uppsala University, 1971.

[15] This distinction between research and development is expanded and clearly conceptualized in K. L. White *et al*, "Improving Health Care Through Research and Development."

FIGURE 18. HOSPITAL DISCHARGE SURVEY FORM

Hospital number	Hospital's number as printed on MP 1968-1
Department number	According to code list
Case paper number	Do not write letters or number of year
Date of birth	Two last figures of year, month and day (each two figures)
Individual number	The three figures can be found on sickness insurance certificate
Sex	1 = male 2 = female
Marital status	1 = never married 2 = married 3 = widow(er), divorced
Date of admission	Two last figures of year, month and day (each two figures)
Form of admission	1 = from domicile 2 = transferred from other department 3 = transferred from other hospital
Date of discharge	Two last figures of year, month and day (each two figures)
Form of discharge	1 = to domicile 2 = to other department (in hospital) 3 = to other hospital 4 = dead, autopsy 5 = dead, no autopsy
Admitted earlier	Write 1 in case patient was admitted for same disease to this department earlier this year, otherwise 0
Insurance office number	Local insurance office according to insurance certificate

Form A shall be filled in for each discharge (including deaths). Occasional transfers between departments without a formal discharge are not regarded as discharges. Typewriter should be employed.

Copy of forms should be sent in every fortnight (preferably the 1st and 15th of each month) to the Statistical Section, National Board of Health, Box, Stockholm 3.

For delivery cases (except abortions) also complete form B.

Diagnosis 1	(Principal cause of stay in hospital) Number and name of disease
Diagnosis 2	Number and name of disease
Diagnosis 3	Number and name of disease
Diagnosis 4	Number and name of disease
E = number and description of external cause	

Diagnosis number	Code of operation	Code of anaesthetics	Cause of death (no. of order 1–4)
			Reserve 1
			Reserve 2
			Reserve 3
			Reserve 4
Special information on patient in long department, sanatorium, etc.			Reserve 5
First admission	1 = not treated for TB earlier in this hospital. 2 = treated earlier as above		Reserve 6
TB bacilli	See code in paragraph 7 on back of form		Reserve 7
Special information on child admitted for care or observation before one year of age			Reserve 8
No. of institution	Refers to maternity institution where born. Not to institution-code		Reserve 9
Birthweight			Reserve 10

Signature of physician | Notes of National Board of Health

Adapted from: National Board of Health (Sweden), *Sluten Kroppsjukvård i Uppsala Sjukvårdregion 1964 och 1965* (Stockholm: 1969), 56.

Figure 19. INSTRUCTIONS FOR COMPLETING HOSPITAL DISCHARGE SURVEY FORM

1. Case paper number. Patients remaining from previous year should keep their old numbers.

2. Form of admission, form of discharge. By "domicile" is meant any form not indicated by code numbers 2–5. If patient first goes home and then proceeds to other hospital, code to number 1.

3. Admitted earlier. Information refers to status under diagnosis 1. If the patient has not been treated at all or for another disease in this department (or hospital), write 0. Disease is regarded as "the same", even if the diagnosis has been worded differently. It is not regarded as "the same" if the patient has contracted the disease (injury) afresh.

4. Diagnoses. Write only one diagnosis on each line. Code number shall be assigned according to "Classification of diseases" (sixth edition)[1]. Diagnosis 1 refers to the condition (disease, injury etc.) the investigation or treatment of which was the main cause for keeping the patient in the hospital. If there was several causes of equal importance and it is impossible to give preference to one of them, refer to any free space on the form and write them there (cum code number) connected by a bracket. There are three lines for other conditions treated, or—in case of investigation or observation—diagnosed. Cases of injury through violence, poisoning, certain diseases of infants etc. shall be double coded. Reference is made to instructions on page 6 in vol. 1 of "Classification of diseases" or on page 4 in vol. 2.

Please observe that patients discharged after observation without a definite diagnosis may be coded to a fifth digit category under number 793.

5. Operations etc. are indicated by code numbers alone (according to "Classification of operations")[2]. To show the cause of the operation a referral number to diagnoses 1–4 shall be written in the column "Diagnosis number".

State operation for diagnosis 1 first, then for diagnosis 2 etc. If more than one operation has been done for the same diagnosis the one of chief importance for the disease should be writen first. E.g. if a hyperplasia of prostate is operated by vasectomy followed by resection of the prostate, the resection should be stated first and the vasectomy on the line below.

If same operations has been done more than once, write a multiplication mark (×) after the code number of the operation, followed by the number of times. If operation has been performed in another department, a zero should be written after the multiplication mark.

6. Cause of death should indicate the immediate cause, i.e. the same cause that is written on the top line on the certificate of cause of death. Note that the numerical order of the diagnosis should be written (not the code number in the Classification). Only one number should be filled in.

7. TB bacilli found in sputum, larynx smear, secrete or urine at any time during the stay:

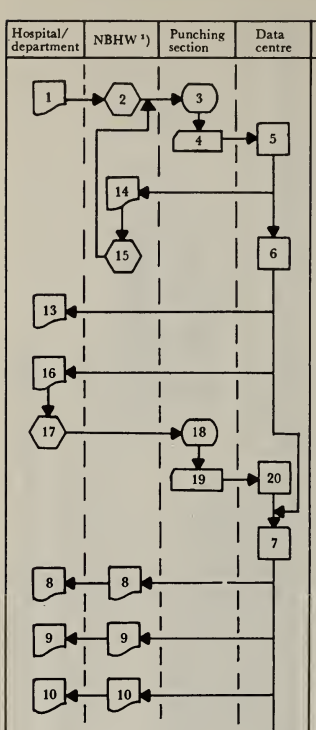
1=direct specimen
2=only by culture or guineapig test
3=only by gastric lavage, punctate or specimen excision

TB bacilli not found:
4=culture or guineapig test done
5=culture or guineapig test not done

[1] This is an adaptation in Latin and Swedish for hospital use of the International Classification of Diseases etc. (seventh revision).
[2] A list of four-digit categories compiled by the National Board of Health.

Adapted from: National Board of Health (Sweden). *Sluten Kroppssjukvård i Uppsala Sjukvårdregion 1964 och 1965* (Stockholm: 1969), 57.

FIGURE 20. AUTOMATIC DATA PROCESSING OF FORM A, 1969



Legend

(1) Forms arrive in NBHW [1]) as they are completed, as a rule twice a month.

(2) Forms are registered and checked before being sent for punching.

(3) They are punched.

(4) The punched cards proceed to:

(5) Automatic control of identification data and structure of individual records (1 record for each hospital episode) on magnetic tape.

(14) List of errors go for:

(15) Correction within NBHW, and are then included in processing of next instalment (as a rule a years discharges are split up on 4–5 instalments). Corrected records go on to:

(6) next stage in machine processing which consists of validity control of data. After this the hospital departments (hospitals) receive (as from 1969 and on):

(13) a preliminary diagnostic index of records so far approved, and

(16) a special correction sheet for each faulty record.

(17) The latter are corrected in the hospital department and dispatched to NBHW for

(18) punching of amended cards.

(19) The amended cards proceed to:

(20) Updating of the bank of information (including all the year's instalments). The material, now being correct and complete, is

(7) processed, sorted and listed, resulting in the following lists and tables:

(8) Diagnostic index pro year and hospital department;

(9) "Report C" (a consolidated table of discharged cases) pro ditto;

(10) "Report D" (a consolidated table of operations) pro ditto;

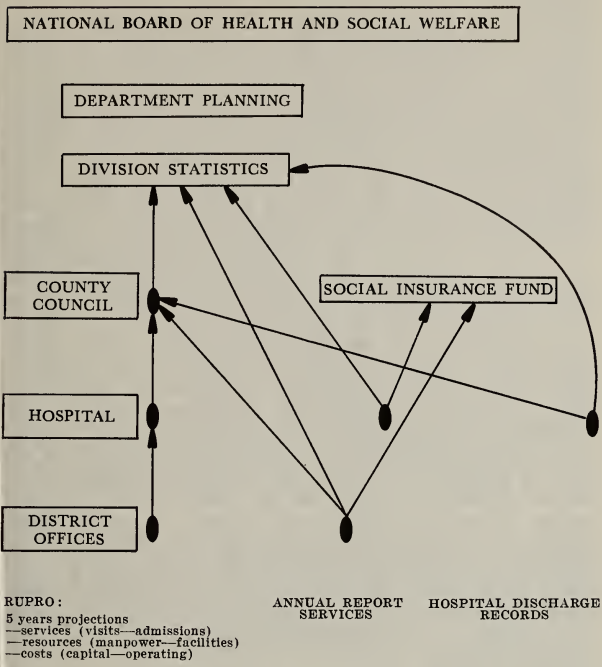
(11) Diagnostic index for the whole Uppsala region ("the research list");

(12) Any other statistical tables.

[1]) National Board of Health and Welfare

Adapted from: National Board of Health (Sweden), *Sluten Kroppssjukvård i Uppsala Sjukvårdregion 1964 och 1965* (Stockholm: 1969), 60.

FIGURE 21. FLOW OF INFORMATION FROM LOCAL TO NATIONAL LEVEL



two activities, research and development, although interrelated, serve two distinct functions. In summary, research is aimed at providing an answer, while development aims at making use of that answer to solve a problem. A key element, of course, is who asks the question. This leads us to the concepts of relevance and accountability in research and development, both within and outside the health sector, a topic much discussed today in several industrialized societies. Indeed, several reports in the United States [16] and the United King-

[16] W. B. Schwartz, "Policy Analysis, Politics and Problems of Health Care," 1056.

dom [17] have recently discussed not only the nature and type of desired research but also the direction and policy of this research and its governance.

Rothschild in the United Kingdom, for instance, argues that because the bulk of research has been academically based and funded by grants, this research has been generated by the individual researcher's intellectual curiosity and is based on the assumption, prevalent in academic circles, that knowledge *per se* convinces. Thus, the researcher assumes that someone, sometime, will make use of this new knowledge. Rothschild refers to this activity as "scientific roulette." Not surprisingly, Rothschild, the head of the Central Policy Review Staff (usually referred to as the think-tank of the British government), recommends that most of the applied research currently undertaken in the United Kingdom should be directed by the government and done through contract. Actually, according to his recommendations the government should be the customer and contractor (the one to ask the question), and the researchers then would try to provide the answers. Further, he suggests that at least part of this applied research should be not only directed but also carried out by government agencies. Others in the United Kingdom, such as Dainton, disagree. He supports the present system, wherein most of the research is governed by autonomous bodies—the research councils—with a great predominance of academicians, and believes that the question of relevance is already taken into account in existing arrangements for selection of research programs. He does agree, however, that these research councils must increase their awareness of national needs and objectives and recommends the creation of a coordinating body, a Board of the Research Councils, that would also act as a bridge between the government and the councils. As to the proposed transfer of research to the departmental agencies, Dainton finds this suggestion unwise because often more than one department stands to gain from the work being done.

A similar debate has arisen in the United States, where it is generally believed that there is no uniform national research policy, and where most of the academically based research has been funded by grants, as distinguished from contracts. A recent trend toward contracts is observable, however, with more explicit policies for research being announced by different levels of government, primarily the federal government. Worth underlining, however, is that the lack of an explicit policy document does not imply lack of policy. Indeed,

[17] Rothschild, "The Organization and Management of Government R & D."

in research, as in planning, the lack of a report or explicit document outlining the research policy of the federal government does not necessarily mean that there is no policy. Actually, it is a principle of administration that leaving policy implicit may result in greater flexibility for the policy makers, and thus their reluctance to formulate explicit policy. Strickland, in an excellent article in *Science*,[18] for instance, disputes the generally accepted perception that the main research institutions in the United States, the National Institutes of Health, have not had a research policy. Actually, by tracing the legislation and its priorities, Strickland conclusively shows that there has been, in the last 20 years, through congressional legislation, a clear statement of purpose, a working consensus to achieve it, and continued and consistent direct financial support of the implementation of a national health research policy in the United States.

The relationship between research and policy is equally important in health services research. Here again, several reports in the United States and the United Kingdom have appeared, underlining the interest in this area.[19] In the United States, in 1967, the National Center for Health Services Research and Development was created to undertake research and stimulate development in the United States health services. Almost at the same time, other legislation was passed by Congress creating comprehensive health planning (Public Law 89–749) and regional medical programs (Public Law 89–239) that were also aimed at stimulating new developments in the United States health services.[20]

Recently there has been a trend toward separating the different components of research and development, cataloging them under four main groupings: policy analysis, information and statistics, development, and research. Some observers,[21] for instance, have suggested for the United States a policy analysis group at the federal level that would be a permanent group of civil servants in the office of the Secretary of Health, Education and Welfare providing professional continuity and support to the policy making process. The information and statistics group would also be in the Secretary's office and would be in charge of data collection and processing of the information

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[18] S. P. Strickland, "Integration of Medical Research and Health Policies."

[19] For example, G. McLachlan, et al, *Portfolio for Health: The Role and Programme of the DHSS in Health Services Research*. The title of this publication is somewhat misleading. Actually, it lists, in comprehensive chapters, the different pieces of research undertaken by the Department of Health and Social Security, but it does not explain how this research relates to policy, nor how the researchers relate administratively to the policy planners. This exclusion seriously weakens the informative value of the report.

[20] Both pieces of legislation are discussed in Chapter 6.

[21] K. L. White, "Health Care Arrangements in the United States: A.D. 1972."

required for planning and evaluation purposes at the level of the Secretary's office. The development group would include the present Comprehensive Health Planning and the Regional Medical Programs and other programs that relate to development. The research group would be established at the agency or departmental level, contracting with or granting funds to academic or other institutions to undertake research.

How are these different groups represented in the Swedish experience? We have already spoken of the policy groups, represented mainly at the Ministry level, and the information and statistics groups, discussed above in the context of data collectors and represented in the division of statistics of the National Board of Health. In the next part of this section we will discuss the research and development groups in the health sector in contemporary Sweden, as well as the relationship between research and policy, on the one hand, and research and development, on the other.

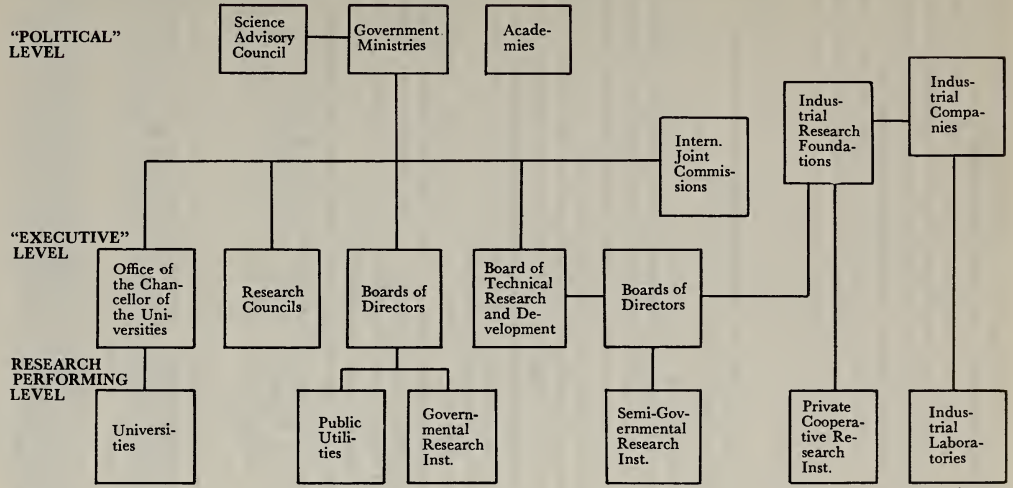
The Swedish Experience in Research and Its Relationship to Policy

What is the relationship between research and policy planning in today's Sweden? Figure 22 shows the different levels of this relationship, which include the political level, where general planning decisions are made and where the national objectives of research are drawn up; the executive, where political decisions are translated into appropriations to institutions and individual scientists; and the practical, comprising the research conducted at institutions, research establishments, and industrial laboratories.[22] At the political level, the Science Advisory Committee, set up in 1962 and chaired by the Prime Minister and comprising approximately 20 researchers and policy makers from the research performing institutions, has the task of serving as a forum for joint deliberations on long-term science policy in Sweden.

Most government research is administered through six research councils, similar in their composition and functions to the British research councils. The members of these councils are appointed for periods of three and six years. The council administering the largest portion of research and development funds (70 million kronor) is the Board of Technical Research and Development (STU), established in 1969/1970 and successor to the Council for Applied Research. Immediately after the STU in terms of funds administered is the National Science

[22] The Swedish Institute, "The Organization and Planning of Swedish Research."

FIGURE 22. ORGANIZATIONAL STRUCTURE OF THE SWEDISH RESEARCH SYSTEM



Adapted from: The Swedish Institute, "The Organization and Planning of Swedish Research," *Fact Sheets on Sweden* (Stockholm: 1970), 1.

Research Council, followed by the Medical Research Council (51 and 47 million kronor respectively in budget year 1972–73).[23]

At the research-performing level there are different groups that carry out research and development projects contracted with or granted by the research councils.[24] Of special interest among these are the research institutes, which are partially autonomous with control of their own budget. Of these, the aforementioned National Institute for the Planning and Rationalization of Health and Social Welfare Services (SPRI) is of particular relevance in health services research and planning.[25]

The National Institute for the Planning and Rationalization of Health and Social Welfare Services (SPRI)

This Institute was established in 1968 as the result of an agreement between the Ministry of Health and Social Affairs, the Federation of County Councils, and the three large cities of Stockholm, Göteborg, and Malmö. At the time it was also hoped that the National Federation of Primary Communes and Municipalities would join these groups in sponsoring and funding SPRI. This Federation, however, has not joined as yet, and it is unlikely that it will do so in the near future. And since the primary communes and municipalities administer most of the social welfare services, the tasks of the Institute in the area of social welfare would seem somewhat limited.

When SPRI was established on January 1, 1968, it assumed control over all the work and staff from three institutions which ceased to exist: the Central Board of Hospital Planning, the Council for Hospital Operational Rationalization, and the organization department of the Federation of County Councils.

Sponsored by the Ministry, the Federation, and the three largest cities, SPRI is funded to the extent of 40% by the Ministry, and of 60% by the Federation and the three above-mentioned cities. The highest decision making body is its board, with a chairman and five

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[23] For a detailed explanation of science and technology in Sweden, see: *Scandinavian Research Guide;* Sverige-Amerika Stiftelsen, *Travel, Study and Research in Sweden;* National Central Bureau of Statistics (Sweden), *Research and Development in Technology and Natural Sciences in Industry 1965–1967;* National Central Bureau of Statistics (Sweden), *Research and Development in Technology and Natural Sciences in Agencies, Research Institutes and Foundations 1964–1966.*

[24] For a brief but comprehensive review of research in the health services in Sweden in the early 1960's, see R. J. Haggerty et al, "Health Services Research in Scandinavia."

[25] Other institutes, the National Institute of Public Health and the National Institute of Occupational Health, also have relevance in basic physiological research on public health and occupational health.

members appointed by the Ministry, and with another twelve members appointed by the Federation and the cities. This board has control over the budget, which in 1970 amounted to 19 million kronor. SPRI has a staff of 30 professionals and 100 employees.

The main functions of the Institute are the stimulation of development and the provision of consultant services, regulation in the areas of administration, planning, and evaluation of health services, and research. As stated in its bylaws, its main objectives are:

> . . . to promote and coordinate the planning and rationalization of health and welfare services in Sweden; to gather and distribute information; to promote the coordination of health and welfare services; and to establish standard specifications for hospital equipment.[26,27]

The main departments of the Institute are planning, organization, construction, equipment and facilities, and the general department.

The *planning department* assists the county councils and the three large cities in preparing their health services plans. As indicated in the previous chapter, the county councils are now required to prepare long-term 15–30 year plans, medium-term 10–15 year plans, and short-term 5 year plans by 1975. Actually, a top priority project within SPRI is entitled "Basic Guidelines for the Scope and Design of a Health Services Plan" and aims at providing the county councils with assistance and guidance both on the modalities of their collection of information and on how to use it for the preparation of the long, medium, and short-term plans.

Besides consultant services, this department administers research, such as a project entitled "Development of Methods for Estimating Medical Care Demand." Actually, the first step in this study was made during October and November of 1969, in cooperation with the county council of Östergötland. The study was a patient census during a four-week period and covered the entire range of medical care. It was complemented by a conventional one-day census carried out in inpatient departments by the Östergötland county council and several other county councils.

Two further studies may serve to illustrate the kinds of research administered by the planning department. One, "Differentiation of Care in Outpatient Treatment in an Urban Area, Göteborg," analyzed the patient composition at outpatient clinics in Göteborg during a one-

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[26] National Institute for the Planning and Rationalization of Health and Social Welfare Services (Sweden), *The Activities of SPRI in 1969–1970.*

[27] The lack of participation of the National Federation of Primary Communes and Municipalities within the Institute indicates a reduced emphasis in regard to welfare services.

year period by collecting data relating to 1% of the total number of persons visiting the clinics. Another research study followed-up a previously completed health check in Eskilstuna. The approximately 1000 people, aged 40–65 years, who had participated in a major health check in 1964 were reinvestigated after five years, thus illuminating the value of public health checks, from both medical and cost aspects.

The *organization department* assists the county councils in improving the efficiency of their administration and organization of health services. Research on the adoption of computers, on staff structure, and on the division of work within hospital units is conducted by this department. For instance, it administers the research, undertaken on a contractual basis, by the University of Lund-Malmö on the administrative integration between social and health services in the experimental health center of Dalby. Also, the reorganization of personal health services, by blocks within the districts, referred to before, is part of a joint project of SPRI with the county council of Stockholm.

The *construction department,* besides consulting and research activities on the design and construction of facilities, also has regulating functions. Indeed, the head of this department is secretary of the Committee for the Construction of Health and Social Welfare Buildings (see "The Regulators," in this chapter), which has to approve all hospital designs before their construction by the county councils.

The *equipment department* works in the establishment of norms and standards for construction and equipment of hospitals and health facilities.

The *general department* is mainly a service department for the Institute.[28]

Development in Health Services Planning

Of the diverse work undertaken by SPRI, one project is particularly relevant in terms of health services planning at the county council level.

As mentioned above, according to the recommendations of the Comprehensive Health Planning Committee, the county councils are to prepare, by 1975, long-term development plans, medium-term plans and short-term plans, according to a defined process and methodology developed by SPRI, in a project referred to as 3006, or "Development of Guidelines for the Preparation of Local Plans." These different plans have to be coordinated and prepared in accordance with the

[28] For a more detailed account of the responsibilities of each of these departments and for a detailed listing of their research work, see: National Institute for the Planning and Rationalization of Health and Social Welfare Services (Sweden), *The Activities of SPRI in 1969–1970* and "SPRI"; and the Swedish Institute, "The Organization and Planning of Swedish Research."

long and medium-term economic plans of the county and regional authorities (see Chapter 3, Section II).

Figure 23 shows the different types of plans the county councils are supposed to prepare. The *long-term development plan* outlines the overall goals and priorities for development in the county commune for the next 30 years, based on information and data prepared by the state and regional authorities. These sets of priorities are reflected in the outline of activities and programs, included in the development program for the county.

The fifteen-year plan, a *medium-term plan,* outlines the priorities and the projected activities of the county for the period of 15 years. This 15-year county commune plan generates the long-term budget, better described as the long-term economic projections, including not only an initial estimate of the operating costs, but also investment and financial projections.

Part of this 15-year county plan is the plan for the health services for which the county is responsible, with specifications for the space, buildings, equipment, and manpower required for the different projected activities of the county for the equivalent time period. This medium-term plan in the health sector is referred to as the *principal plan.*

These 15-year economic projections are divided into periods of five years, and the first five years into periods of one year. These 5-year projections are also referred to as financing and executive plans. Figure 24 shows the different steps involved in preparing the 15-year plan in the health sector, or principal plan. Basically, this process follows three stages and contains three sections.

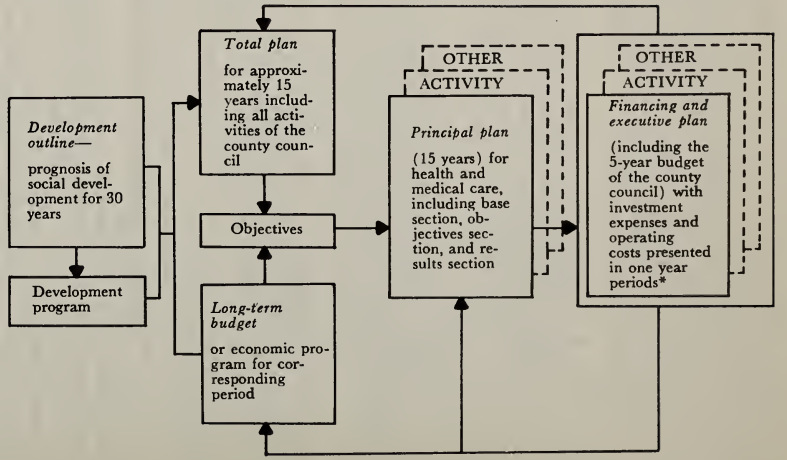
The *base section* of the plan contains an estimate of the expected demand for services for that period of time and of the expected supply of resources and services for the same period.

The *objectives section* of the plan includes the different alternative policies being considered, according to the priorities defined in the long-term development plan and the specific objectives and targets defined in the 15-year plan, according to the levels of expected demand and supply of services, and according to the expected and defined functional and structural changes within the county health services.

The *results section* contains the resources required to meet the plan's objectives, which are outlined according to the different alternatives proposed in the objectives section.

Figure 24 also shows the different steps within each section. Within the *basic section* (underlag), there is the definition and explanation of the content and time perspective of the county plan (A.1), the extent

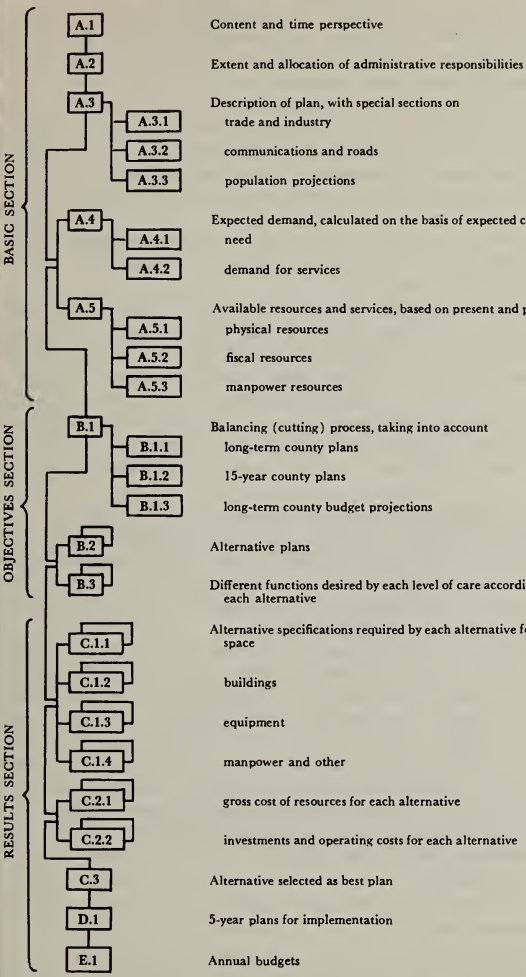
FIGURE 23. DIFFERENT TYPES OF PLANS PREPARED BY THE COUNTY COUNCIL


TYPE OF PLAN
Development outline—
prognosis of social development for 30 years
Development program
Total plan
for approximately 15 years including all activities of the county council
Objectives
Long-term budget
or economic program for corresponding period
OTHER ACTIVITY
Principal plan
(15 years) for health and medical care, including base section, objectives section, and results section
OTHER ACTIVITY
Financing and executive plan
(including the 5-year budget of the county council) with investment expenses and operating costs presented in one year periods*
PLAN PERIOD
30 years
15 years
15 years
5 years

*Includes one-year operation and investment plan by the county council.

Adapted from: Landstingens Tidskrift, 58, 1971, 42.

FIGURE 24. STEPS INVOLVED IN PREPARING THE 15-YEAR PLAN



and allocation of the administrative responsibilities within the county plan (A.2), and the description of the county plan (A.3), with special sections dealing with the development plans within the county for trade and industry (A.3.1) and for communications and roads (A.3.2), and with projections of the county population (A.3.3).

Within this county plan, there is a projection of the expected demand (A.4) for that time period, calculated on the basis of expected changes of need (A.4.1) and demand for services (A.4.2), and of the amount of resources and services (A.5) based on present and projected availability of physical (A.5.1), fiscal (A.5.2), and manpower (A.5.3) resources.

This section finishes with an outline of the required resources to meet the expected demand and the available number of resources supposedly available during that time period.

The second section, the *objectives section* (malsättning), deals with the objectives of the plans and refers to the problem of balancing the demand with the available and projected supply. Since demand for resources tends to be always larger than available and projected supply, the cutting process, more mildly referred to as the "balancing process", occurs (B.1) to take into account the objectives and priorities defined in the long-term development county plans (B.1.1), in the 15-year plans (B.1.2), and in the long-term budgeting projections B1.3).

In this planning process, consideration is also paid to desired structures of health service, as well as to objectives. The guidelines for this structure are provided by the Comprehensive Health Planning Committee (see above). Variance within these conceptual models determines the different alternatives (B.2), depending upon the different functions (B.3) desired by the level of care.

Each structural and functional alternative considered would require a set of specifications, in terms of space (C.1.1), buildings (C.1.2), equipment (C.1.3), manpower (C.1.4), and other resources (C.1.4).

The gross costs of these resources, either capital or operating costs (excluding interest and depreciation) (C.2.1), and the expenditures in investments and operating costs (C.2.2), are calculated with a final evaluation of the different alternative plans, and the one considered best is selected (C.3). A criterion for defining "best" may be the degree of flexibility and possibility of change that the alternative may offer.

The execution of the plan is reflected in the 5-year plans (D.1) and the yearly budgets (E.1).

More Comments on SPRI

Actually, the group in Sweden that most closely approximates a policy analysis group is the staff of the Ministry of Health and Social

Affairs. Most of their analysis, however, is oriented toward short-term solutions to immediate problems and it was to provide a broader perspective for policy analysis that the Comprehensive Health Planning Committee was created. The members of this committee, however, are not involved full-time in policy analysis and provide only partial information upon which "well-informed policies" could be based. It would seem, then, that in Sweden there is no long-term policy analysis group at the state level, whether within or outside the government, that could generate information and analysis for long-term policy. SPRI, rather than being a policy analysis group, is more a research and development institute for planning and rationalization in the county health services.

Nonetheless, with the creation of SPRI, a great stimulus was given to health services research and development in Sweden and today very few research and development projects are conducted in the field of health services in Sweden that are not related to or funded or coordinated by SPRI. And its continued support by the county communes seems to reflect a need for its activities in the local authorities. Actually, their demand for consultant services in preparing their health services plans explains the fact that SPRI is presently thinking of establishing eight regional consultant services, one in each health region, which would be closer to the local authorities, the county communes, and could respond better to their specific needs. But in terms of SPRI's relationship to the national government, its present autonomy does somewhat limit its potential usefulness to the central planning agencies in the health sector, at least in the provision of solutions or answers to the problems or questions faced by those agencies.

And where those state agencies have tried to use and direct SPRI, an institute outside the government, as a policy research group, the SPRI researchers' fear of losing independence and autonomy has rendered the attempts of the state agencies unsuccessful. Thus, although SPRI assists and is helpful to the county communes in research and development, it is of limited assistance, in terms of policy, to the state agencies. Indeed, SPRI, oriented to what Rothschild defines as tactical research, is oriented primarily toward the county communes. But its autonomy and independence from the central state agencies makes this strategic research, however relevant to the local authorities, of limited value for the central agencies. This situation has determined the need for the creation of a policy analysis group within the state agencies. And it would seem likely that in the long run, the recently created and previously described Committee for Comprehensive Health Planning could serve this function.

Chapter 5

REGIONAL HEALTH PLANNING

Section I

URBAN REGIONAL HEALTH PLANNING: THE STOCKHOLM REGION

THE REGION AND ITS CHARACTERISTICS

The metropolitan region of Stockholm, referred to as Greater Stockholm, includes the city itself, an inner zone consisting of 17 suburban municipalities,[1] and an outer zone of 10,[2] comprising an overall region of 1.3 million inhabitants, which represents 16% of the total population of Sweden.

The city of Stockholm was founded as a fortress in the 13th century by one of the early rulers of the Swedish kingdom, Birger Jarl, and was established as the capital of Sweden in the 17th century by King Gustavus Adolphus. A city built of wood, Stockholm, in its early days, was repeatedly subject to great fires, and had to be rebuilt on several occasions. Compelled to rebuild, ". . . the city turned its disasters into opportunity by undertaking to build according to orderly plans." [3]

These orderly plans were prepared by the city planner, called the "conductor," and his office, created 330 years ago, has been in charge of planning the development of Stockholm ever since. As early as 1640, the city adopted master plans for Stockholm and its environs, placing

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[1] Djursholm, Lidingö, Nacka, Solna, Sundbyberg, Danderyd, Saltsjöbaden, Sollentuna, Täby, Boo, Botkyrka, Huddinge, Järfälla, Märsta, Tyresö, Upplands-Väsby, and Österhaninge.

[2] Ekerö, Färingsö, Grödinge, Gustavsberg, Salem, Vallentuna, Vaxholm, Värmdö, Västerhaninge, Österaker.

[3] G. Sidenbladh, "Stockholm: A Planned City," 86.

Stockholm among the world's oldest cities in which growth has been accomplished through an orderly development.

The ability to plan was largely the result of one all-important factor: public ownership of the land by the local authorities. As Sidenbladh points out, "if destructive fires in the city made planning necessary, government control of the land made it possible." [4] Actually, until the mid-19th century, there was practically no private ownership of land in most of Stockholm. The owner of a house paid a ground rent, usually a nominal one, for the use of the land on which the house stood, and this nominal fee served to establish that the land did not belong to the individual user. Home builders were allowed to use land on the condition that they put it to a certain stipulated use and built within the prescribed period established in the master plans.

This first stage in the history of urban planning in Stockholm, characterized by public ownership of the land, was followed, however, by a second stage during the latter part of the 19th century and the beginning of the 20th. During this second stage land was actually sold to private users and control of large expanses of land thus passed to the private sector.

This policy, defined by some [5,6] as one of the greatest mistakes of urban planning in Sweden, considerably constrained and weakened the development of the city master plans. For example, when, at the beginning of this century, city authorities wanted to build wide boulevards following the Parisian model, they were unable to do so because the ownership and control of the land had passed to the private sector.

Today, in the third stage of urban planning, the city authorities of Stockholm are carrying out plans for redeveloping the inner city. In this process the city authorities, with the assistance of the national authorities, are following a strategy of land purchase similar to the urban renewal programs in the United States, that is, they have to buy the land, in theory, at the actual market value. Once it regains ownership, the city government retains control of the land by leasing it rather than selling it. According to the present renewal plans, the city government expects to own half of the inner city and commercial sites by the middle 1970's.

The physical structure of the Stockholm region presents different levels of population density, in concentric zones, according to the monocentric model of demographic distribution in urban settings described

[4] G. Sidenbladh, "Stockholm: A Planned City," 87.
[5] A. L. Strong, *Planned Urban Environments.*
[6] J. Garpe, "Stockholm at the Opening of the Sixties."

by Burgess, Hoover, and others.[7] Table 21 shows the population densities for the different urban zones in Stockholm in 1966, comparing them with those of other cities.

Of all the cities in Table 21, Stockholm has the lowest population densities. Indeed, a comparison of Stockholm, Paris, and London within a radius of 25 km from the center of each city reveals approximately 1, 5, and 8 million inhabitants respectively.[8]

The inner city of Stockholm, with 289,000 inhabitants, or 22% of the population of the entire metropolitan area, has become increasingly attractive to commercial and business interests. It is, today, one of the demographically declining sectors of the region, a result of a general centrifugal trend, which has occurred in all zones of the city, of people moving from the center to the periphery or suburbs, and to surrounding counties. If this trend continues, it is projected that by the end of this century, only 15% of the population of the Stockholm region will be living in the inner city. Indeed, taking all city zones into account, the present population of the city of Stockholm proper, 760,000 inhabitants, is expected to decline to 670,000 inhabitants by 1980. Meanwhile, the total population of the surrounding counties within the metropolitan region, also 760,000 inhabitants at present, is projected to increase to 1,185,000 inhabitants by 1980.[9]

Parallel to this centrifugal trend, there has been a change in the demographic composition of the different zones, a change that is expected to continue for the rest of this century. According to this trend, similar to the trend observed in American cities,[10] elderly populations are increasingly being concentrated in central Stockholm, and younger populations in the suburbs. This trend is clearly reflected in Table 22, which compares the sizes of three age groupings of the populations of the city of Stockholm and its suburbs (0–14, 15–64, and 65+), for 1950, 1965, and 1980 (projected).

Table 22 shows that during the period 1950–1980, the younger population of the city is projected to decline from 20% to 15% and the productive population from 70% to 64%, while the older population is expected to increase from 9% to 21%.

In the suburbs, by contrast, the younger population is expected to increase from 24% to 27% during the same period, while the produc-

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[7] E. M. Hoover, "The Evolving Form and Organization of the Metropolis."

[8] E. Ödmann and G-B. Dahlberg, *Urbanization in Sweden: Means and Methods for Planning*, 71.

[9] Stor-Stockholms Sjukvardsberedning, *Hälso-och Sjukvardsplan 1971–1980: Stockholms Län*, 43.

[10] Presidential Commission on Population Growth and the American Future, *Population and the American Future*, Parts I–III.

Table 21. POPULATION DENSITIES IN VARIOUS ZONES OF NINE METROPOLITAN AREAS

Zone	Population per hectare*								
	Paris 1962	London 1961	New York 1960	Chicago 1960	Moscow 1963	Tokyo 1960	*Stock-holm* 1960	Milan 1961	Amster-dam 1963
Urban core	351	100	298	55	402	136	139	192	112
Central and semi-central area	76	73	55	61	59	147	43	82	47
Whole city area	86	74	64	61	72	146	44	87	50
Suburban municipalities	12	18	11	13		16	3	16	6
Greater city area	50	38	29	24		69	8	41	29
Other suburbs	1	4	2	1		12	0.3	5	8
Whole region	7	9	9	6		25	4	11	12

*1 hectare = 2.471 acres.

Adapted from: E. Ödmann and G-B. Dahlberg, *Urbanization in Sweden: Means and Methods for Planning*, National Institute of Building and Urban Planning Research (Stockholm: Government Publishing House, 1970), 71.

Table 22. PAST AND PROJECTED POPULATION OF STOCKHOLM (S), THE REST OF THE COUNTY (C), AND THE WHOLE COUNTY (S & C), FOR 1950, 1965, AND 1980, BY AGE GROUPS

Age group	Population (in thousands)			Percent of total population		
	1950	1965	1980	1950	1965	1980
I. 0–14						
S	150	131	103	20.1	16.6	15.2
C	91	148	324	24.7	24.5	27.4
S & C	241	279	427	21.6	20.0	22.9
II. 15–64						
S	528	550	432	70.8	69.0	63.8
C	243	405	782	66.0	67.2	65.9
S & C	771	955	1214	69.3	68.7	65.2
III. 65+						
S	67	107	142	9.1	13.5	21.0
C	34	50	79	9.3	8.3	6.7
S & C	101	157	221	9.1	11.3	11.9

Note: Data for each of the years refer to the commune block county with the addition of the Kungsängen commune block.

Adapted from: *Hälso-och Sjukvardsplan 1971–1980: Stockholms Län* (Stockholm: 1970), 45.

tive population remains constant and the elderly population declines from 8.3% to 6.7%. These percentage changes reflect the fact, among others, that young people are more mobile than elderly people.

It is worth underlining that the physical distribution of work places does not follow the same pattern as the distribution of living spaces. Indeed, in 1965, of the total number of work places in the metropolitan region of Stockholm, the inner city accounted for 53%, with the rest of the city accounting for 20%. The suburban counties within the metropolitan region accounted for 25%.[11] It is also noteworthy that although the changes in the distribution of work places follow a pattern similar to that of the residential spaces described above, the trends in the former are much slower than those in the latter.

Linking the living with the work places is the transportation system, which has special characteristics resulting from the unusual geographic characteristics of the city of Stockholm and its metropolitan region. The city of Stockholm, often referred to as the Venice of the North, is

[11] E. Ödmann and G.B. Dahlberg, *Urbanization in Sweden: Means and Methods for Planning.*

actually a group of islands and peninsulas, interconnected by 50 bridges and separated by channels, rivers, and lakes. This geographic configuration has militated against the use of the private car as a means of transport. To go from any suburb to the inner city, the car traveller has to cross several bridges, which would become insurmountable bottlenecks during the morning rush hours, when 200,000 commuters travel from the suburbs to work in the center of the city,[12] if the majority chose private cars as their means of transport. Actually, the majority of commuters, although owning private cars, do use public transport, primarily rail transport, to commute to the urban center. Indeed, public transportation has been used

> . . . by 87 per cent of the riders to work in the central business district of Stockholm, by 71 per cent of those travelling to work in other parts of the city, by 52 per cent of those working in the near surburbs (within 10 miles) and by 35 per cent of those in the outer suburbs. Sven Lundberg, chief of the city's traffic planning department, estimates that 15 years from now these percentages will be respectively 90, 50, 15 and 15 per cent. That is to say, nearly all the people working in the center of the city will travel by subway, but most of those working in the suburbs will drive to work.[13]

This preference for public transport is expected to continue, and this despite the growing ownership of private cars by the inhabitants of Stockholm (from 9 private cars/1000 inhabitants in 1945 to 190 cars/1000 inhabitants in 1965). The effect of car traffic on urban development is, indeed, considered to be negative, but geographical configurations and enlightened government legislation seem to have been effective in controlling that problem in Stockholm.

Car transport has, however, had a positive effect in assisting the expansion of the suburbs of Stockholm. And, contrary to the experience in most metropolitan regions in the United States, this growth has followed a designated line of development, established in the city's master plans. Such deliberate expansion has been possible because, in contrast to inner city land, of which the private sector owned considerable portions during the first half of the 20th century, most of the land in the suburbs, during the same period, was owned by the city and county governments.

Suburban growth has been concentrated in new towns or communities which have been established in the environs of the city of Stockholm. Actually, these new communities were planned around shopping and transport centers, replicating the monocentric density

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[12] E. Ödmann and G-B. Dahlberg, *Urbanization in Sweden: Means and Methods for Planning.*
[13] G. Sidenbladh, "Stockholm: A Planned City," 97.

patterns of the city of Stockholm, with the business district in the center, multi-story buildings in the middle zone, and family homes in the periphery. These communities were initially designed not as independent towns but as living centers within the metropolitan region, referred to as the "dormitories" of the city, of a projected size of approximately 10,000 inhabitants. This size was later expanded to 25,000, because the previous size was considered too small to sustain such social services as schools and health centers for the community.

It has been, however, only since the creation of Vällingby in 1954 that the concept of an independent living and working center has been accepted, with the establishment within the same community of working as well as living spaces, and with each community functioning as a shopping, welfare, and cultural center for its inhabitants. In accordance with this concept, similar to the British concept of new towns, Vällingby has a population of 59,000 inhabitants, and provides 15,000 jobs. Since then, other towns have been planned, the most recent one being Järväfältet, with a projected population of 110,000 inhabitants, and offering employment for 80,000 people.

These new towns are partly self-sufficient in the provision of some social services—such as most health services, except for specialized services, such as tertiary care, and some of the secondary care facilities, that are provided in centralized locations for the whole metropolitan region of Stockholm.

THE HEALTH SECTOR

Figure 25 shows the desired organization of the health services for the metropolitan region of Stockholm, according to the 10-year plans for the health sector of that region.

At the top of the pyramid, or in the center of the regional model (depending on whether one looks at the regional model vertically or horizontally), is the regional central hospital (there are two in the region of Stockholm) that provides the tertiary care services shown in Table 23 for the whole metropolitan region, the secondary care services for a population of approximately 90,000 people, and the primary care services for the immediate neighborhood surrounding the hospital.

For the second level, the normal or district hospitals, the following facilities are legally required:

> . . . specialized departments for surgery, medicine, anesthesiology, x-ray, obstetrics and gynecology, pediatrics, psychiatry, and long-term diseases (mainly geriatrics), with a total of about 300 beds. The population in the area to be covered should be at least 60,000 and preferably 90,000 inhabi-

Table 23. NEW REGIONAL SERVICES FOR THE STOCKHOLM REGION SINCE 1961

I. Inservices
- Department of Rheumatology
- Department of Occupational Medicine
- Kidney Units
  - Department of Nephrology
  - Department of Urology
  - Center for Hemodialysis
- Department of Child Neurology
- Clinical Neurophysiology
- Neurological Rehabilitation
- Department of Clinical Pharmacology
- Phoniatric Clinics
- Audiological Laboratory

II. Attached services
- Department of Social Medicine
- Homes for Mentally Disturbed Children (operated from the Department of Child Psychiatry)
- Unit for children with cerebral palsy and allied CNS disorders (attached to the Department of Child Neurology or Pediatrics)

III. Independent regional institutions
- Mental Retardation (multiple disability, low grades)

Adapted from: A. Engel, *Perspectives in Health Planning*, 1967 Heath Clark Lectures (London: The Athlone Press, 1968), 81.

tants. The other district hospitals should be converted into nursing homes for long-term diseases, or health centers, or—even better—a combination of both, which has been found to be very rational.[34]

Also, these district hospitals are supposed to provide primary care services for the neighborhood surrounding them.

The third level, the annex hospital, is unique to the metropolitan regions of Stockholm, Göteborg, and Lund-Malmö, and is an institution of intermediate care for the chronically ill, with rehabilitative services provided for in- and outpatients. These annexes are satellite hospitals to the district or normal hospitals, to which they belong administratively.

The fourth level consists of the health centers, housing specialists

[34] A. Engel, *Perspectives in Health Planning*, 83.

and urban district officers, and providing primary and ambulatory secondary care for the population in the immediate health district.

The fifth level of care comprises the convalescent homes, which offer semi-inpatient care for convalescents and day care for rehabilitation patients.

The sixth level is domiciliary care, which includes ancillary care provided at patients' homes.

Figure 26 shows the hospital plan for the metropolitan region of Stockholm, with the dotted lines representing projected hospitals to be built after 1975. This plan has been severely criticized for not giving enough priority to the sixth level, or district and home care level. Actually, the 1975 plan does not make provision for the expansion of the present 33 district offices eventually supposed to serve 750,000 inhabitants. This situation has been attributed to the strong pressure of the private medical profession, concerned over the expansion of the public sector.[15]

THE HEALTH PLANNING PROCESS

The Planning Structure: The Decision Makers

As of January, 1971, the Stockholm City Council and the County Council of the Region of Stockholm have been combined into the County Council of Greater Stockholm, which combines the responsibilities of the former metropolitan government of the city with those of the county government which formerly administered the suburbs.

This new County Council of Greater Stockholm is thus responsible for the planning, administration, and most of the funding of the health services of the region of Stockholm. Since 1968, in addition to hospital and other institutional care, county council administration also extends to the district officers who are responsible for the provision of preventive care services and curative primary services and were previously under the administration of the central government. Similarly, the hospitals and institutions for the mentally ill have been the direct responsibility of the councils since 1968.[16]

The new Stockholm County Council has 149 members, who are elected every four years, with an executive committee of 17 members and 10 deputies. As indicated above, it combines the responsibilities of a county council, with primary responsibility for personal health

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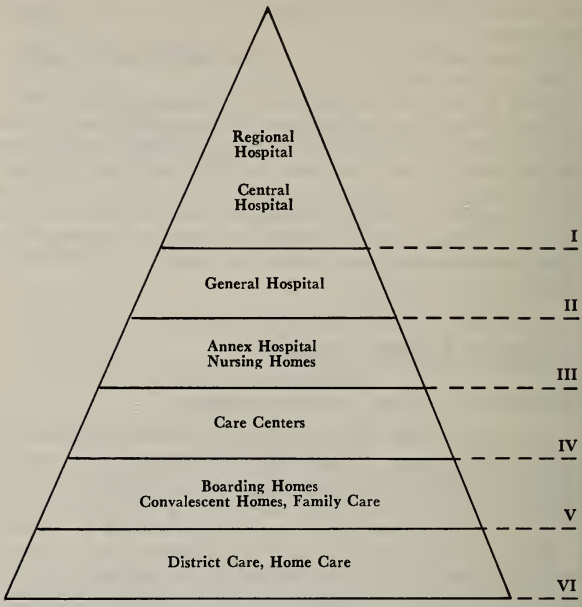
[15] Personal communication, C. Hogstedt, Department of Social Medicine, Karolinska Hospital.
[16] Stor-Stockholms Sjukvardsberedning, *Hälso-och Sjukvardsplan 1971–1980: Stockholms Län.*

FIGURE 25. DIAGRAM OF THE STRUCTURE OF HEALTH AND MEDICAL CARE IN A SECTOR (ADMINISTRATIVE AREA)



I Central hospitals/regional hospitals for institutionalized specialized acute care for the whole sector, general acute care for a limited reception area, and ambulatory care for the immediate hospital neighborhood.

II General hospitals for general acute care for the hospital reception area and ambulatory care for the immediate hospital neighborhood.

III Annex hospitals/nursing homes for aftercare and extended care for each commune block.

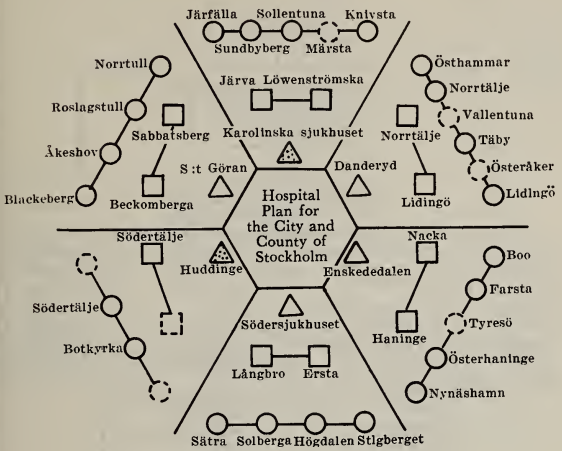
IV Care centers for ambulatory care for commune block or larger population center (preferably attached to annex hospitals).

V Boarding homes, convalescent homes, family care, semi-open care for boarding of extended care and rehabilitation patients and patients who cannot be discharged directly home after a hospital stay.

VI District care/home care.

Adapted from: Stor-Stockholms Sjukvårdsberedning, *Hälso-och Sjukvårdsplan 1971–1980: Stockholms Län* (Stockholm: 1970), 30.

FIGURE 26. HOSPITAL PLAN FOR GREATER STOCKHOLM*



Regional (teaching) Hospital
District Hospital ('Normal Hospital')
Central Hospital
Annex Hospital

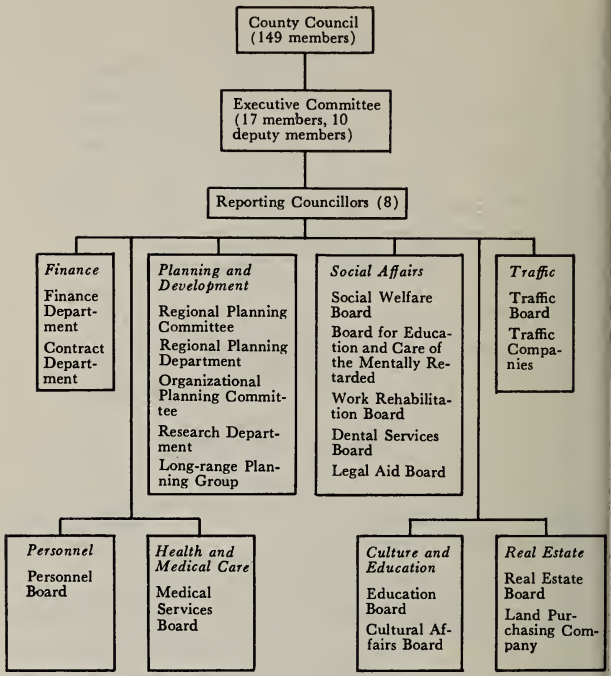
*Dotted lines indicate hospitals to be built after 1975.

Adapted from: A. Engel, *Perspectives in Health Planning*, 1967 Heath Clark Lectures (London: The Athlone Press, 1968), 84.

services, with the responsibilities of a municipality, which has primary responsibility for the environmental health services and most of the social personal services [17] (see Chapter 1 for a detailed description of the functions of the local authorities). This dual responsibility puts Stockholm (and the other two large cities of Göteborg and Lund-Malmö) in a unique situation, because two tiers of government are centralized in one council. This centralization allows for better co-

[17] In the Stockholm region the social services are still, on a transitional basis, under the responsibility of the old municipal and county authorities. This is not the case in Göteborg and Lund-Malmö.

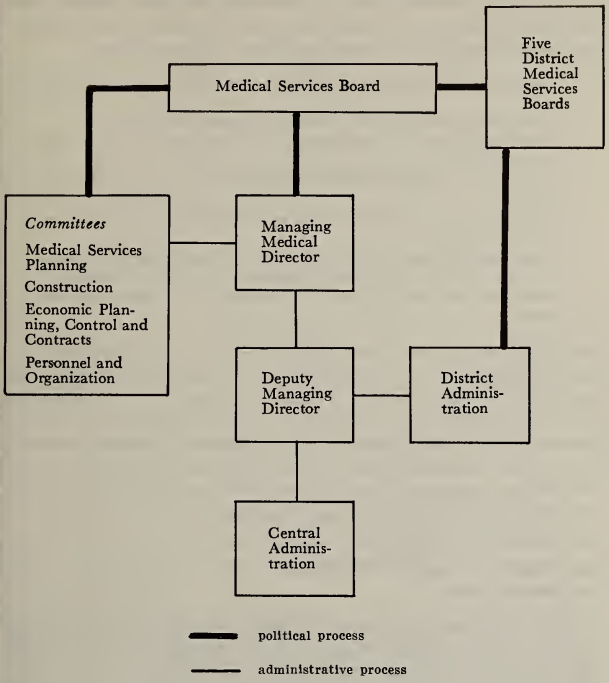
FIGURE 27. STOCKHOLM COUNTY COUNCIL: POLITICAL ORGANIZATION



ordination between personal health services and personal social and environmental services than a division of responsibilities among the two local levels of government, the counties and the municipalities, each independent of the other and with separate taxing powers.

Consistent with this dual responsibility, the centralized health and social services, as shown in Figure 27, are under the executive committee of the Greater Stockholm County Council and the eight reporting commissioners for financing, health and medical care, personnel, planning and development, culture and education, real estate, social matters, and traffic.

FIGURE 28. ORGANIZATION OF THE STOCKHOLM COUNTY COUNCIL MEDICAL SERVICES BOARD



The county council is divided into separate boards, each reporting to one of the commissioners. One of these is the Medical Services Board, which has 16 members or councilmen elected every three years, and is divided, as shown in Figure 28, into four committees: medical services planning; construction; economic planning, control, and negotiations (i.e., budgeting); and personnel and organization.

Under the Medical Services Board are five medical district boards,

with councilmen from the corresponding medical districts serving as members, which are supposed to guide the health development in the districts under the overall policy guidance of the central Medical Services Board. The criteria which were used to delimit these medical districts are complex, but an effort was made to obtain districts:

—including an adequate amount of resources in the large medical specialities;
—where different levels of care are balanced against each other;
—big enough to level out fluctuations in patient load in the short and intermediate term;
—where general hospitals situated near one another belong to the same district;
—taking into account health and sick care delivered by other sources than the county council;
—whose boundaries take into account the new big hospital which the county council built south of Stockholm (Huddinge) and the rearrangement of service areas and districts that will be necessary when patient care starts there.[15]

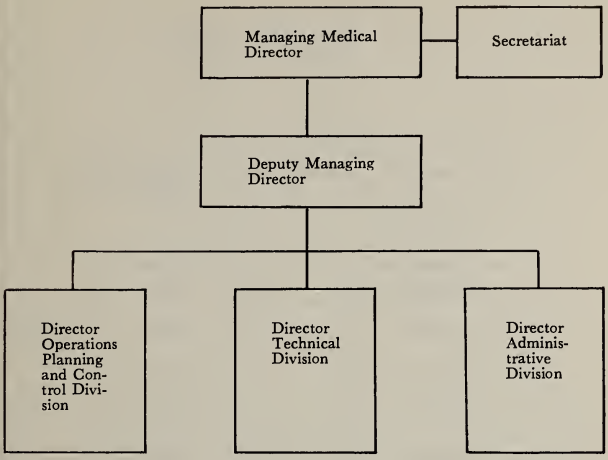
District population size varies from 167,000 in the southwestern district to 446,000 in the southern district. The boundaries of these districts, incidentally, do not coincide with those of the educational or social districts, making coordination rather difficult. This situation has resulted, at the local level—the level of delivery of personal services—in an absence of coordination between the provision of social and medical services, despite the fact that both social and medical services are under the same authority, the county council.

The Planning Structure: The Planners and Administrators

The highest administrator of the health services in the Stockholm region is the managing medical director, appointed for life (until retirement) by the county council, and assisted by the deputy managing directors and the directors of the three divisions of the county administration: the operations planning and control division (in charge of short-term and operation planning, that is, 3 to 5-year plans); the technical division (in charge of budgeting and preparation of the annual budget); and the administrative division (with two subdivisions, one for long-term planning and in charge of developing the long-term, 15 to 20-year plans, and the other in charge of construction and capital investments). See Figure 29.

[15] *Storlandstingskommitten: Delegationen för Sjukvards-Administrativa Utredningar.*

FIGURE 29. THE CENTRAL ADMINISTRATION OF HEALTH SERVICES IN GREATER STOCKHOLM

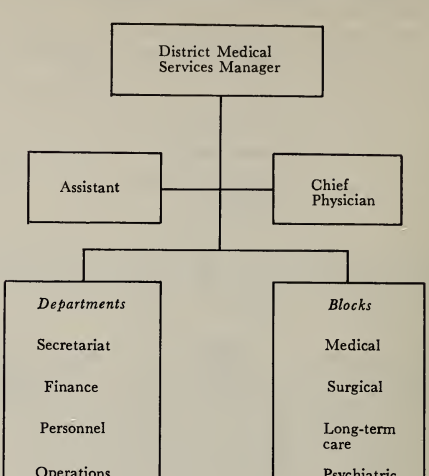


Also under the administrative responsibility of the managing director, as shown in Figure 30, are the five medical district managers and their administrative sections and medical blocks (see Chapter 2 on the block structure).

Under each medical district manager, there are six block superintendents or the medical directors of the six blocks: the medical, surgical, long-term care, psychiatric, pediatric, and general services blocks. One of the districts has a seventh block for all superspecialties or tertiary care services provided for the whole region. This block structure is superimposed over the regional structure defined above. Indeed, the regional model groups services according to levels of care—tertiary, secondary, and primary care services—while the block structure groups the delivery of services by subject and content of care. It is also worth underlining that district medical officers and public health nurses in charge of primary care services are administratively dependent on the district medical manager. Figure 31 shows the regional and block structures in the health sector.

The block structure is a very recent innovation, approved in 1972, and not enough experience has been accumulated to make evaluation

FIGURE 30. THE DISTRICT ADMINISTRATION OF HEALTH SERVICES IN GREATER STOCKHOLM



possible. For a critique of the past experience with the regional mode, prior to the adoption of the block structure, see Chapter 2, Section II.

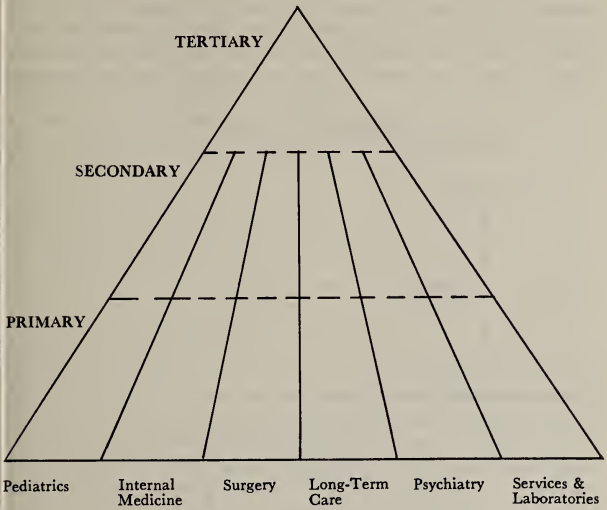
The Process of Planning

Three main divisions within the office of the managing medical director at the county level are particularly relevant in terms of preparing the plans: the long-term planning subdivision of the administrative division; the operations planning and control division in charge of the preparation of the medium and short-term plans; and the technical division in charge of budgeting.

The long-term plan [19] is part of the 20-year development plan for

[19] Stor-Stockholms Sjukvardsberedning, *Hälso-och Sjukvardsplan 1971–1980: Stockholms Län.*

Figure 31. REGIONAL AND BLOCK STRUCTURES IN THE HEALTH SECTOR IN GREATER STOCKHOLM



Greater Stockholm.[20] It contains the desired organizational model to be reached in 10 years, with the projected requirements for reaching that model. Actually, this 10-year plan, submitted in 1969 and approved by the county council in 1970, has to be approved every five years.

The medium-term plan is a three-year plan, which details the programs to be undertaken by the county council and the resources and costs required for their implementation.

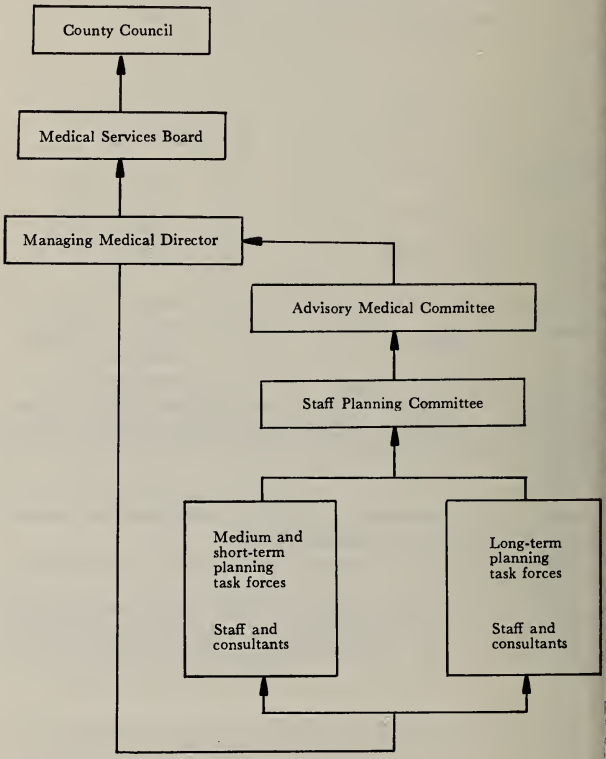
The short-term plan is a one-year plan, made operational through the one-year budget.

As indicated, each of these three plans, the long, medium, and short-term plans, is prepared by different staffs in different subdivisions and divisions of the managing director's office. Besides the staffs,

[20] The time periods for these plans are different and shorter than those suggested by SPRI (see p. 207). It is supposed that they will be expanded and enlarged to follow SPRI guidelines in the future.

there is an advisory medical committee which includes most of the chairmen of the departments of the teaching hospitals and provides recommendations for the managing director. It would seem that they represent the "power structure" of the medical schools in Stockholm. As indicated in Figure 32, there is a staff planning committee which reports to this advisory medical committee. The staff planning committee contains the heads of the staff groups preparing the long,

FIGURE 32. THE PROCESS OF LONG- AND MEDIUM-TERM HEALTH PLANNING IN GREATER STOCKHOLM



medium, and short-term plans, plus the chairman of the advisory medical committee. The main responsibility of the staff planning committee is the coordination of the different types of plans prepared by the task forces on the long and medium-term plans.

The long-term planning task force is divided into different groups which parallel the block structure within the districts, that is, groups on pediatrics, internal medicine, and so on. Each of these groups includes not only staff members from the subdivision on long-term planning, but also consultants, usually academically based physicians and frequently the same professors and department chairmen that sit on the advisory medical committee.

A structure similar to this is seen in the task force in charge of preparing medium-term plans. Indeed, the different groups within this task force have staff members from the division of short-term and operational planning and consultants who are very likely to be the same people sitting on the task force on long-term planning.

It is this observer's opinion that the consultants have a very strong influence on the formulation of the norms, standards, and strategies for the various types of plans in the health sector which are prepared for the County Council. Actually, it may be a measure of this influence that very rarely, if ever, do the managing director, the medical board, and the County Council fail to approve the recommendations generated by the advisory medical committee and its planning task forces. This is also the observation of a student of the Swedish health scene regarding the influence of physicians on the budgeting process.[21] With some local variations, this influence and structure is paralleled in other large cities such as Göteborg and Lund-Malmö, as well as in most counties in Sweden.

It is also worth underlining that a comparable structure is being advocated in the Scottish White Paper on the restructuring of the National Health Services in Scotland. The main merit that is seen in this structure is that it provides the medical profession or its "elite" with a feeling of participation and involvement in the planning process. This process, incidentally, is highly centralized, at the county level, without repeating itself at the district level.

However advisable this process of participation may be, it is certainly not without risks. Indeed, the priorities of the chairmen and professors of the departments in teaching hospitals are not necessarily the same as the priorities of other physicians within the health

[21] For an interesting thesis on the influence of chiefs of services on the entire budgeting process, see E. Borgenhammar, *Power Over the Hospital; A Review of Budgetary Practice in Swedish Medical Care.*

sector or of the public. Actually, it can be postulated that the strong hospital orientation of the Swedish system, with corresponding neglect of primary care centers, where most of the health problems are found, may be due to the predominance of chairmen of teaching hospital departments, with their hospital biases, in the planning of health services. In the words of an astute observer, the Swedish health system is full of white elephants in the hospital sector, with only a very small mouse in the community sector. And considering the true locus of people and health problems, it would seem that more of the latter and less of the former would be required.

Also, this great predominance of academicians, particularly of professors and chairmen, in the process of decision making within the medical sector is seriously handicapping the development of other sectors. For instance, during a visit to an experimental health center in Dalby, which is staffed with five physicians as well as other personnel and serves a population of approximately 25,000 people, this author could not avoid surprise at the absence of x-ray equipment in the center. Actually, it seems that most health centers in Sweden do not have x-ray equipment, in accordance with a national policy. Tracing back the origins of this policy, it was discovered that the task force on radiology at the national level, including several professors of radiology, decided against the installation of x-ray equipment in health centers. The rationale was that general practitioners were not competent to use that equipment. It would seem, then, that the professional development of primary care physicians is being handicapped by this policy dictated by the national task force.

In sum, it appears that the power structure of the medical profession, consisting primarily of professors and chairmen of hospital departments, has in theory an advisory role only, but in practice plays a decisive role, indeed, a controlling role, in the process of health planning in the region of Stockholm.

Data Collectors and Analyzers: The Regional Data Gathering System of the Stockholm Region [22]

Characteristics

The region of Stockholm has planned a unique system of data

[22] This section relies heavily on private communications from Dr. Hans Peterson, chief of the data gathering system in Stockholm, his staff, and the Danderyd Project computer team. It also

gathering, established in 1968, and scheduled for full operation in 1982. This system was designed for the purpose of providing the planning and administrative agencies with a *central population register* common to all functions under the county's responsibility. Indeed, the specialized data banks that deal with only one function and sector, such as inpatient data, blood data, and laboratory data, contribute only a fraction of the information required for the planning and operation of a regional health care system. According to Dr. Hans Peterson, chief of the data gathering system in Stockholm, what is required for these functions is a central population register in which all types of information for all functions of the county can be combined in a rational manner. This "population-centered" approach in data gathering systems, as differentiated from the "facilities-centered" approach, is now possible because of the availability of digital computers capable of storing vast amounts of data in memory devices with which the various users in the region can communicate readily, with response intervals of only a few seconds.[23]

This regional data gathering system is based in the Danderyd hospital and encompasses the entire population of the region of Greater Stockholm. The system plans to cover most of the inpatient and outpatient care provided in that region, through terminals in the hospitals and in some of the medical district officer and local insurance fund offices. Through these terminals, the stored information will be easily and rapidly available to the different types of users within the county.

The system as planned is defined by the following main characteristics:

a. *It covers the entire population of the medical region of Greater Stockholm,* including in its files all potential and actual patients living in that region, with information on their utilization of all health care, inpatient as well as ambulatory, provided in the region. Indeed, the system records all activities related to each patient at the hospitals and other medical institutions, as well as at most of the district doctors' offices.[24] Most of the private care provided by private practitioners may also be included through the local insurance system.

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relies on Dr. Peterson's publications on systems in use and under development in the Stockholm County hospital system: H. Peterson and B. Lindelöw, *Stockholms Läns Landsting Hälso-och Sjukvardsnämnden.*

[23] S. Abrahamsson et al, "Danderyd Hospital Computer System: II. Total Regional System for Medical Care," 30.

[24] There are not as yet terminals in district doctors' offices, nor in local insurance boards.

b. *It is based on a central population register,* including demographic census information for each district and parish, administrative information such as name and address, and medical information for all the population living within the region. Since the central register is available to all concerned within the county, the need for expensive duplication of information in computer registers in various places is practically eliminated. Because of this consolidation, accuracy and security is increased and manual information handling is greatly decreased.

c. *It is user-oriented, providing easy and quick access to the system,* by telephone lines to a very large number of terminals (thirty-two), including both teletype writers and cathode ray tube displays. These terminals have been placed in Stockholm hospitals, and trial installations have also been conducted as district doctors' offices and at the county social insurance office. Each terminal is a combination of a keyboard (like the one on a typewriter) and a picture screen (like a television screen). Information from the data system is retrieved and presented on the screen when the appropriate code word is fed to the computer.

d. *It is a real time system,* that is, the time lapse between a request for information and the answer is only a few seconds. Because the transactions are nearly instantaneous, the user, from his terminal, can interact in a conversational mode with the computer.

e. *It is function oriented,* that is, different functions, from patient file handling to control time mediation, are stored in a core base file of the system, where any function may be introduced without the need for reprogramming. This is made possible by a function generator common to all functions.

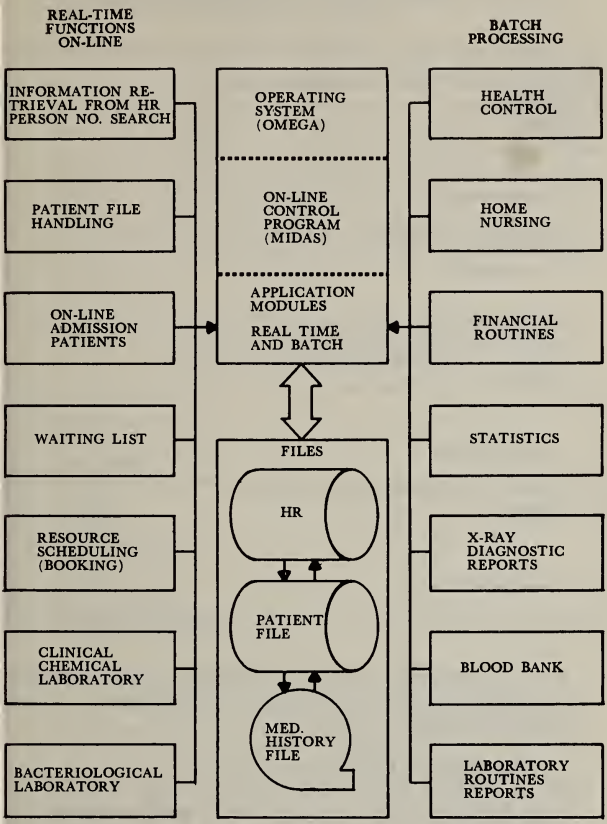
Structure of the System: The Basic File

Figure 33 outlines the overall design of the regional data gathering system for the Greater Stockholm region, including the different structures and files of which it is composed.

The basic file of the system contains the following parts:

The Head Register: One of the basic features of the system is the direct access from the terminal to the head file, referred to as HR (head register). This file contains all basic information (see Table 24) on all potential patients, that is, all inhabitants of the Greater Stockholm region, approximately 1.5 million people, and consists of the following:

FIGURE 33. STOCKHOLM COUNTY DATA GATHERING SYSTEM



a. *CFU* (*State Office for Census and Tax Proposals*) *Information* (*Vital Individual Information*), includes information on the patient's name, age, sex, date of birth, address, occupation, community (including parish) in which he is registered, and relationship

Table 24. THE REGIONAL DATA GATHERING SYSTEM OF THE STOCKHOLM COUNTY COUNCIL: BREAKDOWN OF THE MAIN FILE (HEAD REGISTER)

a. *CFU Information (Vital Individual Information)*
   1 ID Number
   2 Name
   .
   .
   .
   12 Code for county

b. *Critical Medical Information*
   1 Telephone
   2 Blood group
   .
   .
   5 Vaccinations

c. *Information from Previous Inpatient Care*
   1 Hospital
   .
   .
   .
   9 Code of anesthesia

d. *Information from Previous X-Ray Examinations*
   1 Hospital
   .
   .
   .
   5 Classification code

to family members. This CFU information is filed according to an identification number, which is a 10-digit number with the following structure:

. . . $Y_1Y_2M_1M_2D_1D_2X_1X_2X_3X_4$, where Y_1Y_2 represents the year of birth, M_1M_2 the month of birth and D_1D_2 the day of birth A three-figure number ($X_1X_2X_3$) is assigned to each person at birth. This number indicates both the region of the country and the order of birth within that region, the actual day (odd numbers for males and even for females) and X_4 is a 10-module check digit.[25]

[25] S. Abrahamsson et al., "Danderyd Hospital Computer System: II. Total Regional System for Medical Care."

(See Table 25 for the contents of the CFU file by individual.) The CFU file is updated every week from magnetic tapes from the State Office for Census and Tax Proposals.

b. *Critical Medical Information,* which includes (Table 26) the patient's telephone number (both home and work), blood type information, and critical illnesses for which it is important to have information quickly available. It also includes the patient's current medication, especially for preparations such as diamasol and cortisone, as well as information concerning drug and other sensitivities and vaccinations. This file is aimed primarily at providing the basic information required in case of emergency.

Also listed are the critical diagnoses (Table 27). If the person in an emergency has one of these conditions, the computer automatically produces the required critical medical information.

Table 25. CONTENTS OF THE MAIN FILE OF THE REGIONAL DATA GATHERING SYSTEM OF THE STOCKHOLM COUNTY COUNCIL: VITAL INDIVIDUAL INFORMATION

- Identification number
- Name
- Street address
- Zip code and post office
- Occupation
- Nationality
- Pension conditions
- Smallpox vaccination
- Civil status
- Date of marriage
- Guardian's ID number
- Codes for county, district & parish

Table 26. CONTENTS OF THE MAIN FILE OF THE REGIONAL DATA GATHERING SYSTEM OF THE STOCKHOLM COUNTY COUNCIL: CRITICAL MEDICAL INFORMATION

- Telephone (home and office)
- Blood group
- Critical diagnosis
- Critical oversensitivity
- Vaccinations
  —year, month, type, number

c. *Information From Previous Inpatient Care,* which includes information (Table 28) on the dates and terms of admissions and discharge, the hospital, the department, and the diagnosis, operations, and types of anesthesia, according to the International Classification of Diseases. This information is stored chronologically, with the latest admission first.

Table 27. CONTENTS OF THE MAIN FILE OF THE REGIONAL DATA GATHERING SYSTEM OF THE STOCKHOLM COUNTY: CRITICAL DIAGNOSIS

	WHO Code
• Diabetes mellitus	26009–26099
• Hypoparathyroidism	27110–27110
• Porfyri	28940–28941
• Dysgammaglobulinemia	28950
• Coagulation diseases	29500–29509
	29600–29619
• Blood illnesses	29799
	20400–20448
• Epilepsy, spasmodical states	35300–35335
	78020
• Heart diseases	43301, 43302
	43307, 43308
	43311, Y1900
• Myasthenia gravis	74400
• Cortisone treatment	
• AP-treatment	

Table 28. CONTENTS OF THE MAIN FILE OF THE REGIONAL DATA GATHERING SYSTEM OF THE STOCKHOLM COUNTY COUNCIL: INFORMATION FROM PREVIOUS INPATIENT CARE

- Hospital (institution)
- Department
- Date of admission
- Terms of admission
- Date of discharge
- Terms of discharge
- Code of diagnosis } Maximum
- Code of operation } of 10
- Code of anesthesia } each

Since 1969, the outpatient care file has also been included in this file, including the date of visit, diagnosis, and treatment for each visit.

d. *Information From Previous X-Ray Examinations,* which includes information on the organ examined, method of examination, and diagnosis, and also the date, hospital, and department. Table 29 outlines the contents of the information filed on x-ray examinations.

The Patient Register: This file includes information on actual patients, but for a limited period of time and for temporary use only. Indeed, when a person is registered, either as an inpatient or outpatient, a special patient file (PR, for "patient register") is created for him, into which all existing information on him in the head file (HR) and the medical history register (MHR) is automatically transferred. This special patient file contains only selective items on the patient's stay, as registered by the clinician responsible for his care, and it is a mere summary, not intended to be a complete patient record. Actually, many attempts have been made to put a patient's entire medical record into a data system, but the required structure of the information to be fed into the computer tends, in this case, to become too rigid, and frequently too expensive as well.

This special patient registry includes, then, only a summary of the patient's medical record while he is under care and for 30 days after discharge, so that information not available when he is discharged, such as laboratory tests, can be collected and included later.

The Medical History Register: Thirty days after discharge, the information on the patient in the patient register automatically transfers back to the medical history register, which now contains the entire

Table 29. CONTENTS OF THE MAIN FILE OF THE REGIONAL DATA GATHERING SYSTEM OF THE STOCKHOLM COUNTY COUNCIL: INFORMATION FROM PREVIOUS X-RAY EXAMINATIONS

- Hospital
- Department
- Ward
- Date of examination
- Classification code
  - —Organ (part of body)
  - —Method of examination
  - —Diagnosis

summary of the patient's prior and current medical record on magnetic tapes.

Functions and Applicability of the System

The uses of the data gathering system may be divided into (1) routine reporting and processing, and (2) patient and system management.

The first type of use refers to the generation of certain kinds of routine information. One example is information required for routine health control measures. For instance, the National Board of Health has requested that each county provide a complete check-up on every four-year old child. Through the HR file, this demographic and clinical information on all four-year olds is easily and rapidly obtainable. Similarly, a gynecological health control program for all women in certain age groups is handled by this system. The home nursing care program of the county of Greater Stockholm, which takes care of 3000 elderly patients in their homes, is also administered on the basis of information provided by this system.

The other type of use refers to patient care management, that is, to scheduling appointments and resources, for on-line registration of all patients. Actually, the patient may enter the system under one of the following conditions:

a. The patient arrives as an emergency case
b. The patient contacts the department where he previously has been treated for similar disorders
c. A referral from a doctor arrives at a certain hospital department

On the two latter occasions it is suggested that the patient should be treated as follows. The admitting physician decides which resources have to be scheduled for proper diagnoses and treatment. This decision is based on information in the referral form and/or another department (HR-main file, MHR-medical history file) medical summary and other file data.[26]

As soon as the patient has made contact with the system, the basic information from the head file and the medical history file is available in a matter of seconds. If laboratory tests are required, according to the admitting physician's orders, the computer indicates alternative dates and places for the patient to be given those tests, as shown in Figure 34.

Also, except in emergencies, the name of a patient requiring hospitalization passes to the waiting list file. While on that waiting list, the

[26] H. Peterson and B. Lindelöw, *Stockholms Läns Landsting Hälso-och Sjukvardsnämden*, 1.

FIGURE 34. STOCKHOLM COUNTY HOSPITAL SYSTEM: PLANNING AND SCHEDULING FORM

DANDERYD HOSPITAL BOOKING MESSAGE

ISSUE DATE 16 APR 1971
EXAMINATIONS BOOKED AT DANDERYD HOSPITAL

NAME ANDERSSON, ANDERS BENGT CARL

PNR/RNR

ADS BYGGNADSGATAN 33 317 40 TABY

TEL 99 99 99

MESSAGE COVERS TIMES AND PLACES INDICATED BELOW

BRING ALONG MESSAGE AT EXAMINATION

IF UNABLE COME PLEASE CALL HOSPITAL 08–85 00 00

HOUR	DATE	EXAMINATION	INSTRUCTIONS/LOCATION
0940	22 APR 1971	RE-VISIT	
1310	22 APR 1971	FIRST TIME	
0815	26 APR 1971		
1300	04 MAY 1971		
ORTHOPED RECEPTION			
BRING ID-CARD			
ORTHOPED RECEPTION			
CLIN. PHYS. LAB, 4TH FLOOR			
CLIN. PHYS. LAB, 4TH FLOOR			

patient may receive further examinations and treatments. The actual date of admission or booking will depend, however, not only on the length of the waiting list for his category and designated department, but also on the availability of resources in that department. This avail-

ability is registered in the resources file (RR), which contains information about the personnel and material resources available within that hospital and department, as well as the rate of present and expected utilization, that is, the average length of stay for that kind of care and the turnover interval for that department. The expected rate of utilization is calculated by age, sex, condition, and intervention, based on the empirical experience accumulated in the entire file.

In addition to the scheduling of appointments and resources relevant to patient and system management, the data gathering system also provides other routine information relevant to the management of the system, such as daily inpatient censuses and updated daily admissions and discharges. Table 30 shows the information pertaining to inpatient registration that is recorded daily for the entire county, by hospital, department, and ward.

General Comments

This regional data gathering system described above is one of the most complete regional data systems known to this observer. Actually, if offers unique possibilities to the planning agencies, enabling them to do what is more the exception than the rule in national and regional planning, that is, to base planning on thorough information on the health care system. Indeed, the possibilities for statistical analysis of medical and social conditions within the region are far larger than those for any system in the United States, for instance. And this

Table 30. CONTENTS OF THE MAIN FILE OF THE REGIONAL DATA GATHERING SYSTEM OF THE STOCKHOLM COUNTY COUNCIL: INPATIENT REGISTRATION

REPORTS—DAILY
- Inpatient Report (Per Ward)
- New Inpatients Tomorrow (Per Ward)
- Accumulated List of Pre-Admitted Patients (Per Ward)
- Inpatient Summary (Per Hospital)
- Bed Capacity (Per Ward)
- Scheduled Bed Utilization (Per Ward and Department)
- Selected Reserve Numbers (Per Hospital)

REPORTS—WEEKLY
- Report of Missing Final Diagnosis (Per Department)

REPORTS—ON REQUEST
- List of Available Reserve Numbers

opportunity has been realized at a relatively low cost, just 0.4% ($1.5 million) of the overall medical budget of the Greater Stockholm County Council ($400 million).

An additional merit of the system, besides the possibilities enumerated above, is its security and confidentiality. Indeed, the availability of different types of information from different files is subject to separate code numbers and computer checks, which make the system as a whole highly secure.[27] This increase in security could be achieved partly because of the computer required checks and codes and partly because of the decrease, with automation, of human handling of medical information.

The system, however, is not without its weaknesses. Its limitations are part financial, part methodological, and part political. Among them is, first, the cost involved in establishing the terminals of the system in physicians' offices. Indeed, most medical care occurs as ambulatory care, in the physician's office, rather than in the hospitals. But the installation of computer terminals in each office providing ambulatory care would amount to a considerable expense. Methodologically, as well, problems persist in terms of designing a system of recording the whole patient medical record in the medical history file discussed above.

But perhaps the political problems are the most insurmountable and they may explain the slow implementation of the system.[28] Among these problems, the most important factor upon which the success of the system may depend is the collaboration, or lack of it, of the ambulatory care physicians. Indeed, even if the financial and methodological problems were solved, the active collaboration of the physicians working in ambulatory care would still be required for the full implementation of the system and for complete recording of utilization practices of the entire population of the region. This collaboration has not been very active so far. It seems that there is a reluctance of physicians to collaborate and participate in the system by registering the contents of their practice. This reluctance stems from their fears concerning possible control and regulation of their practice. Moreover, these attitudes are not likely to change voluntarily in the near future. How much pressure for change will be exerted on physicians in this respect remains uncertain.

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[27] S. Abrahamsson et al., "Danderyd Hospital Computer System: II. Total Regional System for Medical Care."

[28] When the system was designed, it was expected to be in full operation by 1982. There is today a skeptical attitude toward this date and the year 2000 is the new date frequently mentioned for completion.

A further question should be raised concerning the degree to which this system is actually used by the planning agencies of the Stockholm County Council. According to the data gatherers responsible for the system, it is not extensively utilized by the planning agencies; considerable underutilization exists, in particular, in the area of patient and systems management referred to before. Undoubtedly, time is a variable that may explain this, as parts of the system have been in use only since 1972. The planning agencies' lack of awareness of the potential of the system may be another, partial, explanation of its limited use.

Section II

URBAN/RURAL REGIONAL HEALTH PLANNING: THE SKANE REGION

THE REGION AND ITS CHARACTERISTICS

A traveler going from Stockholm to Copenhagen notices, upon reaching the southern region of Sweden, not only a change in the type of housing, but also a higher demographic density than in the more northern regions of the country. The most noticeable characteristic of houses in the southern rural villages is that they are made of stone, while throughout the rest of Sweden, most rural homes are built with wood. This southern region, known as Skane, encompasses six counties (actually, four and a half counties and a city, Malmö), with a population of approximately 1.5 million people. Its population density (61 inhabitants per sq. km.) is the highest for any region in Sweden, with agriculture as the main productive sector in four of the counties and a service economy in the metropolitan area of Lund-Malmö, which includes the city of Malmö, with 260,000 inhabitants, and the county of Malmöhus, with a population of approximately 450,000 inhabitants.

The Skane region in general, and the metropolitan area of Lund-Malmö in particular, constitute the southernmost sector of Sweden, with close ties to the Danish economy. In the middle 1970's, these ties may be strengthened by the proposed building of a bridge spanning the Baltic Sea and connecting the cities of Malmö and Copenhagen (to be the longest bridge in Europe). In Skane, as in other metropolitan areas of Sweden, there is a flow of population from the city to the

surrounding counties or suburbs. Indeed, Malmöhus is one of the most rapidly growing counties in Sweden today.

Within this southern region, the county of Malmöhus and the city of Malmö occupy a predominant position because of their combined size, growth, and high concentration of employment with respect to the region as a whole.

The County of Malmöhus

The political structure of the county is similar to that of most of the county councils in Sweden described in previous chapters. The highest authority in the county of Malmöhus is the county council, elected every three years, with 102 members now equally divided between socialist and nonsocialist members. The council convenes two or three times a year to discuss and approve the budget and other related matters. The executive committee of the council has 15 members, with a socialist majority, and meets twice a month. Its chairman, elected by the committee, is employed by the county administration on a full-time basis.

Besides the county council and its executive committee, there are several boards, five in all, with elected and appointed officials. One of these is the Medical Services Board, with seven members, three of whom are physicians. They are professors and chairmen of clinical departments in teaching hospitals, and two are councilmen and one is appointed. Under the Medical Services Board, for policy purposes, are the District Medical Boards, with elected officials, councilmen, and appointed members.

Again, following an administrative structure similar to that in other county communes, the Medical Services Board has a secretarial or full-time staff and a managing director of health services, who heads the administration of the medical and hospital care services of the county. In addition to directing his own staff, grouped into several divisions, e.g., planning, budgeting, personnel, and legal affairs, he has administrative responsibility for the five district medical directors and their respective offices.

These district medical directors, dependent in terms of policy on the District Medical Board, but in terms of administration on the managing director of health services of the county, administer not only the hospital and other institutional care within their respective districts, but also the district officers, or specialists and primary

care physicians providing ambulatory care, who are employed by the county authorities.[29]

Again, not unlike the rest of Sweden, district officers work in solo practice, without paramedical or ancillary personnel attached to them. These types of personnel—public health or district nurses, physical therapists, social medical workers, and the like—are dependent directly on the county council.

County Revenues and Expenses

The revenues and expenses for the county of Malmöhus are not dissimilar from those for most of the counties in Sweden.

Regarding revenues, the bulk of the county funds comes from direct local taxation (44% in 1971), which is proportional taxation on all taxable income. The proportion has risen very rapidly in the last 10 years, from 4.8% of taxable income [30] in 1960, to 8.5% in 1971, a figure just slightly above the national average.

This increase in county taxes has been accompanied by a decline in the percentage of tax-derived funds with respect to all sources of county income. Indeed, in 1960, county taxes represented 68% of all county revenue, while this percentage had declined to 44% by 1971.

The second largest source of county revenue (25%) is the county council contributions, which consist of payment for services, income generated from their own public enterprises, and national health insurance payments for services. Actually, the local insurance funds pay 10 kronor per inpatient day to the county authorities (for a total patient cost per day, in 1969, of 242 kronor), and 31 kronor per ambulatory visit (for total costs per ambulatory visit, including x-ray and other tests, of 70 kronor).

Other sources of revenue are transfers (16%); state contributions (10%) in the form of equalizing block grants [31] and also in the form of matching funds for the running of institutions for the care of the mentally ill [32]; loans (2%); and savings (1%).

The overall revenue and expenditures for the county have increased strikingly, from 125 million kronor in 1962 to 1000 million

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[29] There are 55 district officers and 700 full-time hospital physicians in the county of Malmöhus.

[30] Taxable income includes basically the payroll of the employees and the profits and dividends of the employers.

[31] These equalization grants are estimated according to a formula that favors poor counties over wealthy counties.

[32] The administration of these institutions for the mentally ill was only recently delegated to the county council. Previously, they were run by the state authorities.

Table 31. ITEMIZED DISTRIBUTION OF COUNTY TAXES

OPERATING EXPENSES = 7.27%

5.06 Hospital and institutional care (inpatient and outpatient care)
- 3.50 Hospital care
- 0.83 Long-term care
- 0.59 OPD care
- 0.19 Other

0.76 Ambulatory care (out of hospitals)

0.34 Dental care

0.42 Other

0.21 Social welfare care

0.58 Care of the mentally retarded

0.32 Vocational training

0.34 Administration

8.25%

CAPITAL EXPENSES = 0.98%

0.33 Hospital and institutional investments
- 0.30 Hospital investments
- 0.03 Long-term care investments

0.16 Mentally retarded investments

0.26 Administration

0.23 Other

kronor in 1971 (with 880 million in operating costs and 120 million in capital costs).

Regarding expenditures generally, it is worth underlining that out of the county taxes, representing 8.25% of the taxable income, 7.27% goes to operating expenses and 0.98% to capital investments. Table 31 represents the distribution of this taxable income in terms of the different expenditure items.

Of the overall expenditures of the county, 55% is for hospital and institutional expenses, 6% is for ambulatory care, 2% for social welfare care, 8% for care of the mentally retarded, 2% for vocational training, 2% for administration, 12% for capital investments,[33] and 16% for other expenditures.

THE VOLUNTARISTIC APPROACH TO REGIONAL PLANNING

The remarkable increase in county expenditures in Malmöhus, paralleled by similar increases in most of the counties in the region of

[33] Most of the capital investment goes into hospital and institutional care.

Skane, has resulted in the equally significant increase in county taxation described above. This increase has occasioned considerable concern among the county councils in Sweden, and also in the national government. This awareness and concern has been accompanied by a growing recognition of the need for planning of county activities, and, in particular, of the medical and hospital care services, which absorb the largest portion of county expenditures.

Actually, as described in Chapter 3 in regard to the process of regionalization in Sweden during the last decade, it is this author's perception that little local planning has taken place in the health sector, with the result that the model of regionalization approved by Parliament in 1958 has actually not been implemented nationwide. Rather, the implementation of regionalization was left to a voluntaristic approach, on the assumption that a community of interests could be generated among the different counties, which would lead in turn to active collaboration in the implementation of the regional plans. A first step toward this collaboration was the creation of the eight regional committees, with members representing the different counties within each region, which were supposedly responsible for planning the provision and delivery of tertiary care services for those counties. The strengths and weaknesses of this voluntaristic approach have already been described in Section II of Chapter 3.

It is worth underlining here, as a prologue to an appraisal of the Skane regional example, that despite the varied arrangements which have been devised for the implementation of regionalization, personal health services in Sweden are only partially regionalized today. Actually, the question now being raised by health planners in Sweden is whether a denominator of 250,000 people is large enough to be considered a planning unit. Planners in other countries are asking the same question, as exemplified in the current debate in the United Kingdom on the restructuring of health services. Indeed, in that country, the first two Green Papers on this topic [34,35] did consider the district, a denominator of approximately 250,000 people, to be of sufficient size to constitute an administrative and planning unit. It was only in a later consultative paper [36] that this population size was considered to be insufficient, and a second level was established as the planning unit—a second tier, the regional health authority, in charge of planning the personal health services for a region of 1.5 million people or more.

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[34] Department of Health and Social Security (United Kingdom), *The Future Structure of the National Health Service.*

[35] Scottish Home and Health Department, *Reorganization of the Scottish Health Services.*

[36] Department of Health and Social Security (United Kingdom), *National Health Service Reorganization.*

In Sweden, as mentioned before, the administrative planning unit is the county council with an average population of 250,000. Exceptions are the large cities of Stockholm and Göteborg, whose populations are slightly above and below 1 million, respectively. It is worth noting, also, that in Sweden there is no regional governmental level between the county and the national levels which could function as an intermediate tier (a planning tier) between the county (250,000 people) and the whole nation (8 million people).

The small population size of the counties, although sufficient for administrative purposes, is insufficient for planning purposes. This situation has caused concern among some health planners in Sweden about the need for a second tier at the regional level to act as a planning unit. This concern has stimulated the creation, in the spring of 1967, of a regional planning committee by three counties in the Skane region (Malmöhus, Kristianstad, and the city of Malmö), with a combined population of 1 million people (projected to be 1.5 million by the early 1980's). This regional planning committee consisted of two representatives from each of the three county councils and a chairman appointed by the Federation of County Councils. Also, a secretariat with 10 full-time staff members was appointed. And with the creation of this pilot structure, a most revealing experiment in regional planning began.

Two advisory committees were established to consult with this regional planning committee: an "expert" committee, which included staff members from the three county councils, plus staff members from SPRI and the National Board of Health; and a physicians' committee, which apparently included strategic representatives of the medical power structure within the three county communes, with a great predominance of university professors and chairmen of clinical departments.[37]

Both committees—the experts and the physicians—were divided into task forces, according to type of care and specialty. Those task forces from the two committees that dealt with the same types of care and specialty seem to have worked fairly closely together.

The preparation of a regional plan for the three counties took two years and cost 2 million kronor. The final report on the plan was published in 1970[38] and contained, besides recommendations, alternative projections of required medical and hospital resources for the three counties for the period 1970–1980, according to the following

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[37] Only one of the physicians on this committee was a district officer.

[38] Kommitten för Sjukvardsplanering i Skane, *Sjukvarden i Skane: Framtida Organisation och Dimensionering.*

alternative assumptions: (1) that there would be no changes made in the organization or administrative structure of those counties; and (2) that there would be several changes, detailed according to several organizational and administrative possibilities. Among the organizational alternatives suggested, for instance, was an increased emphasis on primary care, with deemphasis of hospital care, to be accomplished through the creation of primary health centers in which district officers, specialists, public health nurses, physical therapists, and social workers would work together, providing health care for a population of approximately 20,000 people.[39]

Another administrative alternative suggested by a minority of the regional planning committee (some members from Malmöhus, plus the chairman), was to integrate the planning and administration of health services for the three counties into one region. According to this recommendation, a permanent second tier, for planning and administrative purposes, would have been established at the regional level. A majority of the staff of the secretariat also supported this recommendation.

However, the majority of the regional planning committee, primarily the medical representatives, strongly opposed this latter alternative. Actually, their main concern, it seems, was that the creation of a regional planning authority would dilute their influence and authority in the planning process at the county level.

Indeed, as indicated in the analysis of the planning process in the region of Stockholm, and as we will see again in the appraisal of the planning process in the county of Gävleborg in the next section, the medical profession, particularly the academic and teaching hospital sector, has an overpowering influence on the process of planning health services in Sweden. Although their function in committee is in theory merely advisory, in practice their advice is almost always followed, making them the controlling group in the process of decision making and planning. This influence is particularly felt in the medical services boards of the county councils. The creation of a regional planning body, a second tier, above the county councils, with separate authority and with controlling and regulatory powers (as opposed to voluntaristic powers), would bypass the present channels of influence and control of the medical profession, which undoubtedly would diminish their influence. It is, therefore, little wonder that the recommendation of the majority of the staff of the regional planning

[39] It is worth underlining that this "working together" of the different professionals and paraprofessionals did not mean working on a team basis, but working in the same building. The health team concept in primary care is not in practice in Sweden.

committee and a minority of the members of that committee was voted down. Adding their voice to this decision were the representatives of Kristianstad county, who were concerned that Kristianstad, the smallest and poorest of the three counties, would be absorbed by the other two.

As a result of this combined opposition, the majority of the regional planning committee voted against the establishment of a regional planning body with compulsory powers, and instead recommended the creation of a voluntary planning body, similar to the American area-wide planning agencies of the early 1960's and with a limited staff of one or two members, which would stimulate voluntary implementation of the recommended regional plan. With the publishing of this recommendation, the task of the regional planning committee was ended, and the machinery established by the staff of the committee, including the advisory committees and their task forces, was dismantled.

Summing up the Skane case, it would seem that the most important aspect of this two-year project was not so much the production of a plan, but rather the establishment of an administrative structure for the preparation of the plan, with recommendations for the means and structure of its implementation. The dismantling of both structures, after the final report and plan was submitted to the three counties, seems to have been a waste of that investment.

In terms of applications beyond Skane, this experience seems to confirm, once again, the character of the "voluntaristic" approach in planning in the United States during the last decade, that is, that the voluntary philosophy in regional planning is "an apology for maintaining the status quo." [40]

Indeed, voluntary cooperation implies the possibility that different groups and institutions coming together on a voluntary basis may achieve common objectives through mutual reinforcement. This commitment to a common objective, in reality, is highly dependent on the perceptions of each of the constituent groups and institutions concerning the benefits they could expect from such collaboration. And it is quite doubtful that each group and institution would voluntarily incur the curtailment of its autonomy that regionalization would require for effective implementation. Furthermore, it is doubtful that the different groups and institutions could arrive at the necessary concert of interests.

An additional obstacle to cooperation is that control of decision making is, in the final analysis, vested in the teaching hospitals. Thus, in

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[40] T. S. Bodenheimer, "Regional Medical Programs: No Road to Regionalization."

the perception of the non-teaching hospitals, collaboration is synonymous with their absorption by the teaching institutions. That the teaching center should be the physical center of the region does not necessarily imply, by their reasoning, that it would also be the main policy maker, armed with the power to plan and direct a regionalized system.

Section III

RURAL REGIONAL HEALTH PLANNING: THE COUNTY OF GAVLEBORG

The county of Gävleborg is to the north of Stockholm and has an economy based on forestry and metal industry. It has a population of approximately 250,000 people, an area of 18,420 sq.km., and a population density of 16 inhabitants per sq.km. The capital, Gävle, has 25,000 inhabitants and contains 10 primary communes. Each primary commune is responsible for the provision of schooling, social personal services, and environmental services, while the county is responsible for medical and hospital care services and for vocational training.

The highest authority in Gävleborg is the county council, with 70 members and presently a socialist majority. The Medical Services Board, under the council, has 12 members, while the District Boards, which are under the Medical Services Board, have 10 members each.

In terms of administrative organization, the highest administrator in the health sector is the managing director of health services. Under him are the hospital directors, who are in charge of the administration of the hospitals within each district. It is worth underlining that in this county, as in most rural county councils, the district officers (50 in all) are administratively responsible to the managing director of the county, not to the hospital district director.

As in Malmöhus, the county revenue comes mostly from direct local taxation. A proportional tax of 22% of taxable income is divided into 8.5% for the county and 13.5% for the primary communes. In terms of expenditures, 65% of the county's entire budget of 468 million kronor goes to hospital care, and 12% to ambulatory care.

This county, which, in terms of organizational and administrative structure seems to be fairly average for a rural county, is unique, however, in having prepared a 10-year plan. This plan was prepared

by the division of long-term planning of the office of the managing director of the county, in cooperation with several task forces, dominated by medical professionals. The plan envisions a change in primary care practice, to be accomplished through the establishment of several health centers in which teams of professionals and paraprofessionals would care for a population of 20,000 people. In order to implement this proposal, the district officers, as well as the other types of health personnel, would be made administratively dependent on the district hospital director. This proposed change was motivated by a desire to decentralize the administration of primary medical care.

In terms of hospital care, the requirements within the 10-year plan were calculated on the basis of beds required for different population sizes, as indicated by the National Board of Health and by SPRI.

In the preparation of the plan, and in accordance with the overall guidelines suggested by the National Board of Health, the medical advisory committees have had a strong influence on the definition of the norms, standards, and strategies that constitute the 10-year plan. The implementation of the plan is carried out by the county administration.

Actually, the plan outlines the projected manpower and facility requirements which must be met to sustain the present level of demand and the present structure of the system. Although the bases for the determination of the plan's projections are well documented, there is a ring of uncertainty in the plan, due to the lack of control by the county over those resources and services for which a larger denominator is required. As indicated above, the small size of the county makes it an unsuitable unit for regional planning.

Chapter 6

FURTHER COMMENTS ON POINTS OF POSSIBLE RELEVANCE OF THE SWEDISH EXPERIENCE TO THE UNITED STATES[1]

In the previous chapters, an attempt has been made to describe and appraise the major features of national and regional health planning in Sweden and to comment on the possible relevance of the Swedish experience for the United States. This chapter is intended to serve as an epilogue, summarizing those aspects of the national process of health planning in Sweden that may have bearing on the present debate in the United States on national health insurance. The first part discusses the relationship, usually assumed in the United States to be a causal one, between the health insurance system and health care delivery. The second part deals with the infrastructure required for the process of national health planning and its relevance to the present status and functions of different groups in federal and state establishments.

Section I

THE INSURANCE SYSTEM AND ITS RELATION TO THE SYSTEM OF ORGANIZATION OF HEALTH CARE

In the United States, a great debate in the political arena is

[1] Since completion of the drafting of the original manuscript on Labor Day, 1972, several changes have occurred in the federal health establishment. Those changes considered relevant

under way on the desirability of some form of national health insurance which would cover most of the population for at least large medical expenditures. From very ambitious and comprehensive insurance programs to less demanding, categorical insurance programs a wide range of opportunities and alternatives exists from which, at least in theory, the public will ultimately choose.[2] Much as this debate may be needed, and much as some comprehensive form of insurance may indeed be required, there is the risk that whatever type of national health insurance the Congress of the United States will pass, it may be presented as a panacea, and the solution to what is usually referred to as the "crisis of the nonsystem of the American health services."

Implicit in this point of view is the assumption that the type and source of financing determines the type and nature of the organization of medical care.[3] However, the Swedish experience, which is similar to that of most European countries, shows this assumption to be unwarranted. Indeed, it would seem to indicate that although national health insurance may be a necessary step toward the provision of full health care coverage for the entire population, it is *per se* not sufficient to stimulate or determine the type of organization of health services that is required to make this commitment possible. In fact, the relationship between insurance and the type of medical care organization is not a causal one, and in Sweden, as in most European countries, the delivery system and the insurance system are run independently of each other. The Swedish medical care delivery system is administered by the county authorities who, under the general supervision and regulation of the National Board of Health, plan, administer, and own the facilities and services in the personal health sector. The insurance system, on the other hand, is run by local (county) insurance boards; in terms of policy and administration, it is dependent on the Social Insurance Board and entirely independent of the county authorities. The insurance system is, in fact, a billing system by means of which insurance contributions from employers, employees, and the state are collected to reimburse the providers—the local authorities—for part of their services. These two systems,

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to the subject of this chapter are either noted or commented on in "last minute" footnotes. The restructuring of some components of the "Health" side of the Department of Health, Education, and Welfare, does not, however, alter the content of the overall relevance of the main comments, remarks and recommendations made in this work, although these were written twelve months earlier. If anything, these changes further strengthen the validity of these comments.

[2] For a survey of the large number of proposals for a national health insurance, see Congress of the United States of America, "National Health Insurance Proposals," *Hearings Before the House Committee on Ways on Means* (1971).

[3] Among others, this point of view is represented in E. W. Saward and M. R. Greenlick, "Health Policy and the HMO."

then, the delivery system involved with the organization of health care, and the insurance system charged with part of the funding, are separate; the latter is national in scope (the standards of administration of the local insurance funds are fairly uniform across the country), while the former is local and varies, within certain national guidelines, from county to county.

Thus, if one wishes to explore the extent to which the introduction of national health insurance can solve the problem of medical care organization in the United States, an important question is the degree of relationship between these two systems. In other words, to what extent can one system be changed according to the requirements of the other and what direction should such changes take? Or more simply, does insurance influence organization or vice versa? To answer these questions, it may be worth pointing out that in Sweden, the system of delivery preceded rather than followed the insurance system. And when a national insurance mechanism was adopted, it by no means led to changes in the types of medical practice but instead strengthened existing patterns. In this respect, the insurance mechanism may be considered more of a consolidating force than a stimulant of the reorganization of health care. Indeed, as in other countries where a national insurance mechanism was adopted, the Swedish insurance mechanism took the health services system as "given" and did not alter, stimulate or change the prevalent organizational structure. In fact, even the recent changes in the Swedish insurance system known as the 7 kronor reform were motivated principally by the desire of the administrators of the delivery system for a simpler billing mechanism, and it was the administrative requirements of the delivery system that determined a change in the insurance system, not vice versa. And, as indicated in Chapter 2, the change in the payment plan of the insurance system was not primarily intended to change the organization of medical care.

This pattern has also emerged in the United States, e.g., with the Medicare program. In the light of the experience with this program, which has used an insurance philosophy, it can be postulated that Medicare has left unchanged (and some may say reinforced and strengthened) the system of providing medical care in the United States.

In summary then, in Sweden, as in most European countries, the planning, administration, and regulation of the delivery of personal health services are in the hands of different agencies than those which administer health insurance. And, if that experience is relevant to the United States, it would seem that, parallel to the political and professional attention presently being paid to national health insurance,

concern should likewise center on the development of the planning, regulating, and administration systems which are indispensable for a restructuring of health services in this country. Actually, if the crisis in the American "nonsystem" is mainly due, not to problems of financing, but, as I would postulate, to problems of organization, then there should be a concomitant concern by the promoters of national health insurance with organizing the health services system and the process of their national and regional planning, administration, and regulation.

Thus, the lack of distinction between insurance and organization, and the confusion stemming from considering the insurance mechanism as the equivalent or determinant of the type of organization of medical care, has led to the erroneous assumption that a centrally financed national health insurance would create a monolithic national health service. Actually, Sweden has a system of centrally financed and locally administered insurance, and, at the same time, great variety (too much according to some) in the organization of health care delivery, with services that are owned, planned, administered, and partially funded by the local authorities. And in view of the Swedish experience, it is entirely possible that the proposed national health insurance could be centrally financed and regulated, locally administered, and still have as much variety and diversity in the organization of health services as the public would tolerate.[4]

Actually, the growing awareness that the insurance issue in the United States may not solve the medical care crisis explains the recent arrival of Health Maintenance Organization (H.M.O.) proposals on the political scene. In these proposals, it is assumed that money, supposedly from a national insurance scheme, would be channeled through some type of prepaid funding to certain types of practice, e.g., group practice. A basic assumption of this scheme is that the supply side, the system, can be stimulated and changed from the demand side. Here again, the distribution of resources is supposed to be regulated and guided primarily through the "invisible hand of market forces." [5] The main emphasis in this view is on modification of existing

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[4] It is interesting to note that most of the present political debate assumes that variety in the delivery of health services is preferable to uniformity. The main rationale for this value judgment is another assumption, i.e., that variety also means more choice. It is noteworthy, however, that little evidence has been adduced for or against this assumption, and it is entirely possible that the opposite may be true, and that uniformity may be a prerequisite for choice. Actually, most observers of the United Kingdom and the United States would agree with Brotherston's statement that the average citizen in the United Kingdom has more freedom of choice of medical and hospital care within the supposedly uniform National Health Service than in the supposedly varied American health services. See J. H. F. Brotherston, "National Health Programs in Other Countries."

[5] For a critique of the market approach and its strategy for change in the health services see, V. Navarro, "National Health Insurance and the Strategy for Change."

structures by a system of incentives, with heavy reliance on the initiative of the private sector instead of state control, for the improvement of the delivery system, reflecting, as Harold Laski noted, that

> most Americans have a sense of deep discomfort when they are asked to support the state . . . . They tend to feel that what is done by a government institution is bound to be less well done than if it were undertaken by individuals, whether alone or in the form of private corporations.[6]

Parallel to this reliance on the private sector, however, there has been the recent creation, at the federal and state levels, of different groups that could generate the infrastructure for national and regional health planning in the United States. The next section analyzes these groups and comments on the elements of similarity and dissimilarity with their approximate Swedish counterparts.

Section II

THE ORGANIZATION SYSTEM: THE PROCESS OF DECISION MAKING

Within the broad categories described in Chapter 3 and shown in Figure 35 in the conceptual model used to analyze the process of national health planning in Sweden, it is worth defining those groups at the different levels of government in the United States that could be considered the rough equivalents of the groups of data collectors, data analyzers, and data users described previously. At the risk of oversimplifying a complex situation, and for the sake of brevity, it is possible to describe groups, agencies, and institutions within government whose respective activities reflect one of the various functions pertinent to the overall process of national and regional planning.

POLICY PLANNERS AT THE NATIONAL AND STATE LEVELS

As indicated in Chapter 4, the top policy planners and analyzers at the national level in Sweden, i.e., those who propose policy alterna-

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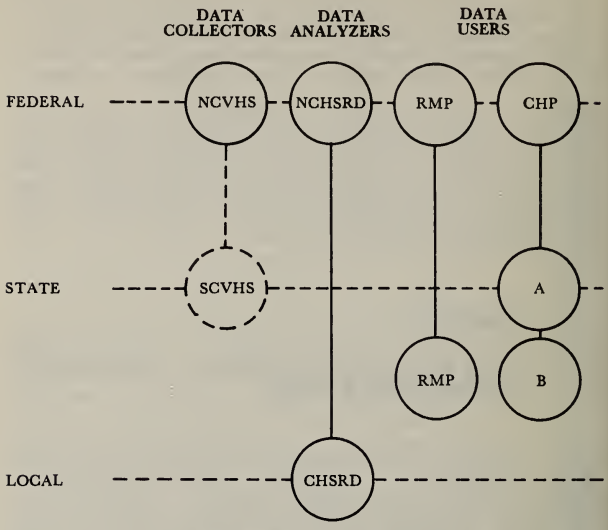
[6] Quoted in H. Seidman, *Politics, Position, and Power: The Dynamics of Federal Organization.*

FIGURE 35. DIFFERENT GROUPS RELEVANT TO NATIONAL AND REGIONAL HEALTH PLANNING IN THE UNITED STATES



NCVHS = NATIONAL CENTER FOR VITAL AND HEALTH STATISTICS
SCVHS = STATE CENTER FOR VITAL AND HEALTH STATISTICS
NCHSRD = NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT
CHSRD = CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT
RMP = REGIONAL MEDICAL PROGRAMS
CHP = COMPREHENSIVE HEALTH PLANNING

tives to the decision makers (the Cabinet) are the Ministries. In the health sector, alternatives proposed by the Ministry of Health and Social Affairs may be prepared by (a) the staff of the Ministry, (b), the Health Planning Council, (c) the Comprehensive Health Planning Committee, (d) the Royal Commissions, and (e) the Planning Department of the National Board of Health. Also, there is a trend toward centralization of policy planning and analysis in the Ministry of Health and Social Affairs, with a heavy input from the Planning Department of the National Board of Health and a lesser input from the Royal Commissions, until recently the most important group in

policy analysis and planning at the national level in Sweden. Another characteristic of the Ministry is the continuity of its staff, allowing for continuity in its policy.

In the United States, the top policy planners and analyzers in the health sector are dispersed in the White House offices, mainly among the staff of the Council of Domestic Advisors and the Office of Management and Budget, and in the Secretary's office of the Department of Health, Education and Welfare (H.E.W.). These staffs, and also the staffs of the Presidential Commissions and the different agencies within H.E.W. prepare policy proposals. Top personnel of these agencies and offices are political appointees and as such change according to political vagaries, unable to provide the sense of continuity at the senior civil service level that is found in the Swedish system. Indeed, this discontinuity in office leads to a lack of long-term perspective, and to emphasis on short-term perspectives that determine their active role as crisis solvers more than policy planners.

Actually, it would seem a condition for long-term strategy in health planning that, first, a group within the H.E.W. Secretary's office be appointed which would have primary responsibility for long-term policy planning and analysis in the health sector in the federal government; second, that this group should comprise senior civil servants who would be in a position to establish continuity and "institutional memory" in the planning process.[7] It is important to note that this group would prepare but not choose the plans, choice being the prerogative of the decision makers or political appointees, in accordance with the political structure and philosophy of the central administration.

At the second level of policy in the United States, i.e., the Health Services and Mental Health Administration (HSMHA) within H.E.W., there is a profusion of programs, most of them categorical in their orientation, i.e., disease, age, or income-oriented.[8] These different programs have responded to what John Gardner defines as

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[7] H. Seidman, *Politics, Position, and Power: The Dynamics of Federal Organization*. Also, for a general analysis and recommendations on the relationship between research and policy see K. L. White and J. H. Murnaghan, "Health Care Policy Formation: Analysis, Information and Research."

[8] At the time of going to press, the different programs that used to be under HSMHA were grouped in different agencies, namely the Health Services Administration, the Health Resources Administration, and the Communicable Disease Center. This reclassification is recognized by the author as a trend towards reducing the categorical structure within the "Health" side of the Department of Health, Education, and Welfare. But even within the newly established structure, however, the programs still follow a categorical approach. Thus, the comments made here in this chapter are also applicable to the new structure.

> the vending machine concept of social change. Put a coin in the machine and out comes a piece of candy. If there is a social problem, pass a law and out comes a solution.[9]

Indeed, as Senator Ribicoff states

> because we rely so heavily on the programmatic approach—passing a program whether we discover a problem or a part of the problem—and rely so little on a comprehensive manner—our efforts often are marked by confusion, frustration, and delay.[10]

This pattern, which applies to most federal activities, is particularly evident in the HSMHA administration and reflects a categorical rather than a functional approach. Indeed, in the profusion of different programs, e.g., Medicare, Medicaid, Maternal and Child Health Programs, Children and Youth Comprehensive Health Services, Comprehensive Mental Health Centers, Neighborhood Health Centers, Migrant Labor Health Programs, Health Maintenance Organizations, the Regional Medical Programs, etc., etc.,[11] each program has its own eligibility, funding, and administrative requirements that frequently conflict with those of other programs. In this respect, the greatest structural difference between the National Board of Health in Sweden and the HSMHA in the United States, as indicated in Chapter 2, is that the latter follows a categorical approach and the former has now adopted a functional approach, e.g., planning, administration, research, and development.[12]

The recent creation of the Division of Health Care Development within HSMHA in H.E.W. may represent the intention to coordinate these different programs and assume a more global approach.[13] Still, the absence of a unit of long-term planning in HSMHA that could assist the policy planners at the Secretary's office and the White House in preparing long-term proposals for the health care of the

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[9] J. W. Gardner, *No Easy Victories.*

[10] Congress of the United States of America, "Modernizing the Federal Government," *Hearings Before the House Committee on Government Operations* (1968).

[11] All these programs were still in existence at the time this monograph went to press.

[12] It is worth underlining that in the proposed structure of the Department of Health and Social Security in Great Britain, a similar functional approach is being taken. Personal Communication, Dr. Henry Yellowlees, Deputy Senior Medical Officer.

[13] This Division of Health Care Development incorporates the current development programs of HSMHA: Comprehensive Health Planning Service, Regional Medical Programs, the Hill-Burton Program, the Health Maintenance Organization, and the National Center for Health Services Research and Development.

entire population may be a serious handicap for the achievement of a long-term strategy of health planning in the United States.[14,15]

Actually, the Comprehensive Health Planning Service within the Division of Health Care Development, the group that could, at least in name, constitute a long-term planning group, is several layers below the policy level, buried in the structure of HSMHA.[16] At present it is stimulating the development of state and local A and B agencies across the country and thus the infrastructure for a planning process that would take place on a nationwide basis. However, it lacks the function of proposing alternative plans to the Director of HSMHA, or to the Secretary of H.E.W. It does not, nor does it apparently intend to, stimulate and assist state and local planning agencies in preparing long, medium, and short-term plans; nor does it have the regulatory functions and power over manpower and facilities at the national level that the long-term planning department of the National Board of Health in Sweden holds.

Considering the experience of that country, it would seem advisable to establish a long-term planning group, working with or within the CHP group at the federal level, that could assist, as does the Department of Planning in the National Board of Health in Sweden, the policy planning group at the level of the Secretary in preparing the various long-term federal plans in the health sector. Also, and as part of the required long-term perspective, the CHP group in the federal government should stimulate the preparation and development of long, medium, and short-term plans by the state and local levels of government; i.e., federal funds in the health sector should not be approved at the state and local level unless the expected expenditures are justified according to state and local long and medium-term plans. This suggestion may sound radical to some, but it is the opinion of this writer that unless the planning process encompasses a long-term perspective, there is not much chance of solving the short-term problems.

A similar situation exists at the state and local levels. At the state level, the Comprehensive Health Planning A Agency has, at least in

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[14] Actually, what passes as health services planning within the federal government is widely scattered among its different branches, departments, divisions, and units. For instance, according to a recent survey of health manpower programs by the Bureau of Health Manpower Education (BHME) of the National Institutes of Health, one of the main health manpower groups in the federal government, there are 150 such programs distributed among federal agencies which are completely outside their purview of responsibilities.

[15] By press time, a new office of Planning and Evaluation had been established under the office of the Assistant Secretary of Health, and this may serve this suggested function.

[16] This program was slightly upgraded in terms of its apparent importance in the federal hierarchy, providing for the establishment of a National Advisory Council on Comprehensive Health Planning to the Secretary, H.E.W.

theory, the mandate of planning health services (personal and environmental) for the state. This mandate is increasingly being strengthened, with these agencies adding some teeth (control and regulation) to the planning process.[17]

The B Agencies at the regional level have a similar function, with their decisions subject to approval by the A Agencies.[18] Both A and B Agencies, however, have not done much planning as such. Until recently without much power, their planning was largely voluntaristic in approach and categorical in nature. And so far only two states have prepared state plans, both of them highly categorical and not dissimilar to the plans previously prepared by state health departments.[19] Absent in both plans were long-term perspectives, i.e., long and medium-term plans, and a comprehensive approach, that is, a plan of medical care for whole populations, not just a few sectors or conditions. Actually, most planning agencies, whether at the state or local level, are not yet even engaged in preparing comprehensive long-term, medium, or even short-term plans. For the most part, they have established mere guidelines for the approval or disapproval of local demands and projects, and at this time theirs is more a regulatory than a planning role, with the criteria for regulation independent of their still largely undeveloped planning function.

It is interesting to note, however, that there is in fact an increasing demand, mainly at the local level, for state and local levels to develop such plans. Until recently and within the present planning process, when a local community wanted to build a hospital, it was up to them to prove or disprove the needs of the proposed facility. Needless to say, the local community very rarely has the information or the competence to prove or disprove the "need" for that facility, and when its request is not approved, as happens more frequently now due to the strong concern with costs, the response from the local level is to demand the needed "proof" from the regional and state level. In turn, regional and state planning agencies find it increasingly difficult to prove or disprove anything without state or regional plans that would put guidelines and priorities within a space and time perspective. Aware of this limitation posed by the present situation, some state planning agencies have started preparing statewide plans that, while not constituting rigid master plans, could offer

[17] See Secretary Richardson's address to the Institute of Medicine in Washington, D.C., May 10, 1972.

[18] Region is here used to denote a smaller unit than the state, i.e., equivalent to "area."

[19] California State Department of Health, *California State Comprehensive Health Services Plan* (1971), and Oregon State Department of Health, *Oregon State Comprehensive Health Services Plan* (1972).

points of reference for generating the criteria for planning and regulating the health services within the state.[20] It is then to be expected that more state and regional planning agencies will follow a similar pattern; i.e., they will begin to prepare long and medium-term state and regional plans. And in this process of plan preparation, the methods followed in Sweden and explained in Chapters 4 and 5 are relevant to the United States experience.

REGULATORS AND CONTROLLERS

This category includes the group(s) in charge of stimulating and regulating the implementation of the plans. The strategies for stimulation and implementation vary in their degree of directness and can be categorized as follows:

a) Simple communication of objectives (the most indirect strategy);
b) Forecasting with a consequent chance for interested parties to adjust their behavior by taking forecasts into account;
c) Use of tax and other incentives and subsidies;
d) Dependence on detailed norms and standards backed up by legal codes and sanctions;
e) Direct intervention and initiation of change.

In the United States, the stimulation of planning personal health services at the federal level has been mainly via strategies a) and c), while the national level in Sweden also employs strategy b) in the form of long and medium-term plans, and strategy d); for instance, by the requirement for central government approval of new physician posts and new construction at the local level. In the United Kingdom, all five strategies are available and used.

Of course, the reference here is to the major strategies for stimulating implementation of the plans, since to a lesser or larger degree they are all present in the three countries. Actually, it could be postulated that in all three countries there is a long and steady trend form a) to d) and, some may add, to e).

In the United States, for instance, stimulation by the federal government has been based on the incentive philosophy, for the most part leaving the allocation of resources to the "invisible hand" of the free market mechanism. It is questionable, however, whether mere incentive is going to provide enough leverage for the required changes within the health services system. For instance, it is doubtful that

[20] Navarro (ed.), *Proposal for a Comprehensive Health Plan for the State of Maryland.*

incentive alone will solve the problem of the "underserved" areas in the United States. Indeed, it is difficult to see how this problem can be solved without solving the question of the "overserved" areas. It is equally doubtful that the redistribution of resources required to solve both problems can be effected without recourse to measures belonging to strategy d), i.e., controls backed by codes and sanctions. One may well postulate that it is next to impossible to address the problem of maldistribution of physicians, for instance, unless the federal or state governments have the power, as does the central government in Sweden, of controlling, in consultation with the medical profession, the distribution of physicians in the country.

Another problem of manpower maldistribution in the health sector relates to the poor distribution of specialties within the medical profession. Several studies have indicated that there are twice as many surgeons in proportion to population in the United States than in England and Wales, and more surgeons than pediatricians.[21] It is doubtful that these maldistributions will be solved merely by incentives. Left to itself, the unneeded specialty may well increase in oversupplied areas, increasing the overutilization of resources by physicians.

Here again, the Swedish experience with the regulation of specialty distribution within the medical manpower pyramid is worth considering. A paragovernmental body comprising government officials from the state and local authorities and representatives of the medical professions and of the medical schools decides on the type and number of residencies that should be available each year and thus controls indirectly the output of the medical teaching institutions according to the need of the health sector and to the priorities set up by the Health Planning Council.

Similar comments as those relating to the regulation of manpower in the United States could be made on the regulation of health institutions and facilities, although both the federal and state governments have played a more active role in regulating the distribution of facilities than of manpower.[22] And the number of states that regulate health facilities construction—public and private—through the "certification of need" legislation is increasing rapidly.

Actually, twenty-two states now have such legislation, which regulates most of the facilities construction in the health sector; six others are in the process of adopting it.[23] A key feature in most states is

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[21] R. Stevens, *American Medicine and the Public Interest.*

[22] A. R. Somers, "Regulation of Hospitals."

[23] Most of the certification of need laws attempt to cover all health care facilities. Oregon and

the interrelationship of the certification of need process with the state's comprehensive health planning programs, which would considerably strengthen the power of the A and B Agencies. Also, and complementing these state laws, other federal laws have been passed by the Congress that add further teeth to the power of health planning agencies; Section 1122 of the Social Security Amendment (P.L. 92–603), for instance, provides planning agencies with the right of review over capital expenditures in health facilities.[24] Under this amendment, health facilities, in order to obtain reimbursement for their capital expenses under any federal reimbursement program, must submit their proposals to review by regional and state comprehensive health planning agencies prior to construction.

In all these laws, the assumption is that the expansion and shape of the facilities sector can be guided by controlling capital expenditures. Only recently, and only in some states, has there been an awareness that control of capital expenditures alone (3 per cent of all health expenditures in the United States) is not enough to guide the expansion of the health sector. Consequently, controls over operating costs have been implemented. One example is the recent creation of a Hospital Services Cost Review Commission with authority to set hospital rates in the State of Maryland, which is to begin operation in 1974.[25]

The relationship between planning and regulation, however, is not without its difficulties. Indeed, as indicated in Chapter 2, unless the norms, standards, and general criteria used in regulating the system are generated and produced by the planning groups, the regulators will evolve their own plans, making the work of the planning agencies largely irrelevant. An example is hospital construction as regulated by the Hill-Burton agencies, which in some states are independent of the CHP A Agencies. Where this is the case, the regulatory agencies tend to develop their own criteria independently of those of the A Agencies, and to limit the planning tasks of the latter as regards facility planning.

Thus, as indicated in Chapter 4, with regard to the national health planning process in Sweden, it would seem that unless the regulating group is dependent functionally, and I would add administratively, on the planning agency, planning is not likely to be followed by regu-

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Rhode Island, however, cover only hospitals while Oklahoma covers only nursing homes. For an extensive review of certification of need legislation, see W. J. Curran, "National Survey and Analysis of State Certification of Need Legislation for Health Care Facilities."

[24] S. R. Gottfield, "The History of Health Planning in the United States."

[25] Maryland Senate Bill, No. 359.

lation and will be deprived of much of its force. However, this conclusion should not lead to the opposite extreme, that is, to the perception of the planning agency as exclusively performing regulatory activities. Actually, the present positive development in the United States of giving the planning agencies some teeth in the form of controlling and regulatory powers could well kill any true planning potential unless they are given the resources required for both planning and regulating. Again, the administrative and functional relationship between hospital planning and regulation in the Swedish National Board of Health, where the regulating group is a division within the hospital planning department of the Board, and their regulatory criteria are the criteria of the planning group, may be worth considering in this context.

DATA ANALYZERS: RESEARCH AND DEVELOPMENT

Health services research as an academic and policy endeavor is a very recent development. In the United States, for instance, the first major step in affirming the value of research and development in the health services field was the creation, in 1967, of the National Center for Health Services Research and Development within the HSMHA of H.E.W., establishing for the first time a federal center for health services research and development. In addition to legitimizing these areas in endeavor nationwide, the National Center has stimulated the development of the field by the creation of local centers for research and development, the majority of these based in academic settings.

In spite of the Center's importance to and positive effects on health services research across the country, it was initially not assigned a prominent position within the federal health establishment. Its place was several levels below the office of the Secretary and, as pointed out by some, buried within the HSMHA bureaucracy.[26] This low priority was also reflected in budget terms. In 1972 all research and development in the federal health sector (of which the National Center for Health Services Research and Development is just a part) amounted to 0.3% of national health expenditures and 1.1% of federal health expenditures, comparing quite unfavorably with the expenditures that the country and the federal establishment make in biomedical research, i.e., 2.3% and 8% of national health expenditures, respectively.[27] Research and development in health services being

[26] *Drug Research Reports*, "The Blue Sheet," 15:19 (1972).
[27] K. L. White, et al., "Improving Health Care Through Research and Development."

a new and not yet firmly established field, it was one of the main objectives of the Center to stimulate and legitimize this sector via research, training grants, and the establishment of research and development centers. The Center, which is under considerable academic influence, values highly its independence within the federal establishment and is seen by some as an enclave of academia in government. Actually, according to some,[28] its main *modus operandi* was to create knowledge and to translate it into medical care literature, on the assumption that knowledge *per se* would convince and influence decision making. The Center's relative isolation from the policy makers, however, particularly from the H.E.W. Secretary's office, has tended to diminish its impact on policy in the federal establishment; its influence, considerable and extensive in academia, was thus restricted in terms of its contributions to decision making at the federal level. Actually, it is open to question whether the Center was ever structured as a research group which would influence policy. But whatever its initial nature and the type of its assignment, the Center today is not a policy research center of direct assistance to the policy and decision makers, nor does such a center or group exist within the federal establishment. Thus, the basis for making "informed" decisions at the top federal level is limited because of the absence of a group called upon to provide the necessary information. Indeed, there is no group of policy analyzers that can formulate the answers (and research is basically the provision of answers) to the short and long-term questions of the decision makers at the top policy levels in the United States.

In Sweden, the Ministry staff, as a policy analysis group, assist the decision makers, the Cabinet, in their immediate short-term decisions. But the use of this staff as a policy analysis group for long-term policy is also somewhat limited, most of their assistance being aimed at helping the decision makers in the short-term running of government, i.e., the so-called crisis solving processes. In fact, it was the need for a group concerned exclusively with long-term planning that stimulated the creation of the Comprehensive Health Planning Committee in 1970, whose functions roughly resemble those of the policy analysis group suggested by Seidman [29] and White,[30] among others, to be created in the office of the Secretary of H.E.W.; i.e., to provide information upon which long-term policy can be based.

The relatively short experience of this Swedish planning committee

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[28] *Drug Research Reports*, "The Blue Sheet," 15:19 (1972).
[29] H. Seidman, *Politics, Position, and Power: The Dynamics of Federal Organization.*
[30] K. L. White, "Relationship Between Health Policy and Research."

limits the analysis of its possible relevance to the United States. Also, a distinction between the planning committee in Sweden and the policy analysis group proposed in the United States is that the latter would be within the Secertary's office, while the former is interministerial and outside the Ministry. It would seem that the United States proposal might guarantee better coordination between long and short-term policy planning and analysis than the Swedish arrangement. On the other hand, the risk of a long-term policy analysis group being submerged in daily crises and "fire fighting" tasks may be less in the Swedish than in the proposed United States structure.

To complement such a policy analysis group, several authors and legislators in the United States have suggested the creation of other federal and nonfederal policy analysis groups that could assist federal decision makers in the

> art of seeking to help the decision maker choose a course of action by investigating the full problem, searching out objectives and alternatives and comparing them in the light of their consequences by bringing expert judgment and intuition to bear on the problem.[21]

Senator Beall, for instance, has proposed a National Health Policy Institute within the federal government which, as the National Institutes of Health, would be

> relatively independent of the political machinery but with a mandate to respond to requests for policy advice on issues both of immediate and of long-term concern to the Congress, the Executive, and regional health-planning groups as well.[22]

Others, such as Schwartz, have suggested that such an institute, while partially funded by the federal government, should be set up outside government, in the newly appointed Institute of Medicine of the National Academy of Science, supposed to be a "dispassionate group whose exclusive concern is with public policy issues."

The closest analogy in Sweden to the institutions proposed in the United States would seem to be the National Institute for the Planning and Rationalization of Health and Social Welfare Services (SPRI), although, as indicated in Chapter 4, its role is more one of development than of medical care research and policy analysis.

Most of the activity of SPRI is directed at tasks such as initiating and promoting the preparation of the different types of long, medium,

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[21] W. B. Schwartz, "Policy Analysis, Politics and Problems of Health Care."
[22] As quoted in W. B. Schwartz, op. cit.

and short-term plans required from the county authorities by the central government, particularly by the Comprehensive Health Planning Committee. Another development activity is to stimulate and assist the county councils in implementing the national policy of coordinating and integrating medical with social services at the primary care level, such as in Dalby in southern Sweden. In summary, SPRI, as a paragovernmental institution at the central level, has the role of stimulating the development and implementation of new policies, accepted by both the national and local authorities; its role is much more restricted, however, in terms of policy analysis within the central government than that envisioned for the proposed institute in the United States.

The modalities of institutionalizing this function of stimulating policy development are difficult to define precisely within the United States federal health structure. Recently, there has been a trend within the federal government to consider the Regional Medical Programs as partly undertaking this function, e.g., with the assignment of stimulating the creation of Health Maintenance Organizations (H.M.O.) across the nation.[33] It would seem, however, that in order to maximize the relationship between planning and development, the Regional Medical Programs should be functionally and administratively dependent on the Comprehensive Health Planning Agencies. Let us assume, for instance, that within the national and state health planning strategies there is a provision for the stimulation of H.M.O.'s or prepaid group practices. It could then be the responsibility of the Regional Medical Programs to assist, technically and financially, in their development, in accordance with the state and regional plans prepared by the Comprehensive Health Planning A and B Agencies and monitored and regulated according to the criteria and outline prepared by the planning groups. A condition for this development would be, of course, a close working relationship between the planners, the regulators, and the developers.[34]

In Sweden, the national planners and regulators are, as indicated in Chapter 4, at the central government level, with the regulators being part of the planning department. The developers at the national level, however, are a paragovernmental group, i.e., SPRI, sponsored both by the central and the local governments, and with close working relationships with the latter. In its policy, however, SPRI follows

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[33] *Drug Research Reports*, "The Blue Sheet," 15:12 (1972).

[34] According to the Budget of the U.S. Government for 1974, it seems that this development function is incorporated within the Comprehensive Health Planning Agencies, with practical disappearance of the Regional Medical Programs.

national policy, established by the central planning group and regulated by its regulating division. This administrative relationship follows a functional distribution of responsibility (as compared to the categorical distribution of responsibility in the United States) that is worth considering. Of course, in the United States much of the local facilities are owned by private groups, in contrast to ownership by local authorities in Sweden. Still, the administrative relationships between planning, regulation, and development, and between central and local interests in Sweden merit attention, particularly in view of the fact that the federal government, although it does not own the facilities, certainly funds a very large part of the institutional and a substantial portion of the ambulatory care furnished at the local level in the United States.[35]

DATA COLLECTORS

The National Center for Health and Vital Statistics is attached in a staff relationship to the Office of the Administrator of HSMHA. Besides collecting vital statistics, the Center collects other information relevant to national health planning, of which the National Health Survey is best known.[36] Covered by these surveys are nationwide data on mortality, morbidity, and utilization of hospital and ambulatory services and expenditures. This information is obtained from various household and hospital surveys; ambulatory care office surveys are projected. The value of this information, however, is somewhat limited since it is only part of the body of information collected and processed by other agencies within the federal government, such as the Bureau of Health Manpower Education of the National Institutes of Health, the Office of Economic Opportunity, the Veterans Administration, etc. Actually, it is fair to say that in the health sector, there is as yet no infrastructure for a comprehensive national data gathering system that would allow continuous reporting of the national utilization of all hospitals and institutions (e.g., length of stay, procedures performed, costs). The absence of such a system is even more obvious in relation to ambulatory care.

A further limitation exists in the restricted use of the information from the National Health Survey for state and regional health

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[35] Congress of the United States of America, "Basic Facts on the Health Industry, *"Hearing Before the House Committee on Ways and Means* (1971).

[36] Series of the National Center for Health Statistics. Publication of the Health Services and Mental Health Administration, Office of Information, Department of Health, Education and Welfare.

planning. Indeed, the small size of the samples in that survey strongly limits the applicability of the information obtained for the purposes of state, regional, or local plans. To solve this problem at least partly, several methods and techniques have been developed for translating and applying national data to the state and local level, although these methods are not widely utilized because of inherent limitations.[37] These strictures seriously handicap "informed" planning processes, particularly in view of the fact that most of the states do not have state centers of health statistics. A 1968 proposal to create such centers with the assistance and encouragement of the federal government has not yet been implemented, although the value of state centers for health and vital statistics that could collect, either continuously or sporadically, information for planning purposes should be obvious.[38] Also, similar to the RUPRO experience in Sweden, it would seem advisable if different units within the system were to report not only current information but also projected required resources—capital and operating—for different time periods. This information would permit an assessment both of present and future developments as perceived by the different units of the system, and afford the perspective required for long and medium-term planning.

The difficulties of establishing a nationwide data gathering system in the United States are symptomatic of the nonsystematic nature of medical care in this country. As the Swedish experience shows, a systematic process of medical care is the prerequisite to a systematic process of data gathering in the health sector. The Swedish experience also shows, however, that the presence of the infrastructure to create a nationwide data gathering system (with the added advantage of having a universal number for each citizen), although necessary, is not sufficient to create, and even less make use of, a nationwide data system. Actually, the potential of such a system at the regional level has begun to be explored only recently (see Chapter 5).

THE ADMINISTRATIVE STRUCTURE OF THE PLANNING PROCESS

The different groups that participate in the planning process in the United States, i.e., the data collectors, the data analyzers, and the

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[37] For further discussion of this point, see V. Navarro (ed.), "A Survey of the Health Planning Process in the State of Maryland."

[38] A new proposal for the development of state health gathering system appears in The Cooperative Federal-State-Local Health Statistics System, Department of Health, Education and Welfare, Health Services and Mental Health Administration.

data users (the planners as well as the regulators and the developers) have been briefly described and appraised in the previous section. Figure 35 showed the different groups at the federal, state, and local levels that represent these functions of data collection, analysis, and use.

In summary, the data collectors are present at the federal level in the National Center for Health and Vital Statistics, and there is a prospect of similar centers being created at the state level. Among the data analyzers, a relevant group is the National Center for Health Services Research and Development at the federal level, with some centers at the local level which have strong liaison with academic centers. As to data users, the Regional Medical Programs have representation at the federal and regional levels, but an as yet undecided task. It would seem, however, that lately there has been some emphasis on considering the Regional Medical Programs as the branch for the development and implementation of health services.[39]

The other group of data users comprises the Comprehensive Health Planning Agencies at the federal, state and local levels. These agencies follow the regular political channels at the state and federal levels, with some variations at the local levels. By relying on the established political structure in the case of A Agencies, the Comprehensive Health Planning Program differs from the Regional Medical Program which bypasses this structure and instead strengthens centers of power such as the teaching institutions which are usually outside the formal political machinery. At the B or local level, the situation is somewhat similar to the Regional Medical Programs, since the Comprehensive Health Planning B Agency may be located in a voluntary agency, such as an areawide planning agency, also outside the formal political machinery.[40] These A and B Agencies are, as indicated previously, presently acting more as regulating than as planning agencies, and it is doubtful that they will be able to develop full planning competence unless more resources are allocated to them.[41]

These different groups (all having different functions) are structured vertically (see Figure 35) and there is little relationship among them. Each group is the result of different legislation, and each has its own constituency that determines its independence. This exclusively vertical structure seriously handicaps the planning process at the national,

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[39] By the time the last touches were added to this book, the Nixon Administration had decided to eliminate the program altogether.

[40] V. Navarro, "The City and the Region; A Critical Relationship in the Distribution of Health Resources."

[41] The average size of a Comprehensive Health Planning Agency is three staff members.

state, regional and local levels. The data collectors, for instance, may be collecting and processing data that may not be relevant to the needs of the planning agency. Similarly, most of the research carried out by the local academic groups may be equally limited in terms of the interests and needs of the local planning agencies.

It would thus seem advisable to establish a horizontal relationship among these different groups at the federal, state, regional and local levels that would be better adapted to a distribution of the functions relevant to the planning process. The model in Figure 14 in Chapter 4 could be considered as a framework for the level of relationships among these groups; regulation, data collection, data analysis, and research and development could be done by the already defined groups within the framework established by the planning groups. It is interesting to note that the prominent role given to the Comprehensive Health Planning Agency in the present discussions on restructuring the system and in different proposals for a national health insurance may reflect an awareness of this need. According to this model, the regulators and developers, as well as the data collectors and analyzers, should be closely related to and dependent on the planning group; the function of those groups is perceived as part of a process which is guided by the plans prepared primarily by the planning group and acted upon by the decision making group.

In addition to these horizontal relationships at the three levels of government, it would seem advisable to create two vertical systems, related but separate: (1) the insurance system, which would include the collection and distribution of funds, and (2) a national and regional planning system, which would incorporate the functions of health services planning and regulation.

Both systems, in my opinion, should be based on the present political structure of the country at federal, state and local levels instead of creating independent sources of power outside the regular political channels at the different levels of government. As indicated before, the first system, the insurance (or billing) system, could be centrally or federally funded, and administered either federally and/or at the state and local levels. These different possibilities are represented in different proposals for national health insurance now being debated in the U.S. Congress.

The second system, i.e., the national and regional planning system, would use whatever leverage is offered by the funds channeled through national health insurance to change and improve the health care delivery system.

These two systems would be administratively separate but functionally interdependent. Indeed, the implementation of provisions making

the expenditure of public funds (national health insurance funds) dependent on the approval of the publicly controlled and administered planning system could be the most powerful leverage for changing the privately owned and administered health care system in this country.

A note of comment is required here to answer those authors who question the feasibility of political separation between private interests and public political authorities. Ellwood and others, for instance, have questioned the feasibility of establishing a public planning and regulating system that is not coopted by private groups.[42] Historical evidence in this and other countries, however, shows that although this cooptation can certainly take place, it is not unavoidable, and not without possibilities of redress. For instance, in Sweden, the overproduction of secondary and tertiary care specialists and the neglect of primary care physicians was indeed due to the great influence exercised by university based physicians in the manpower planning bodies at the national level. The increasing cost of medical care, however, is having its effect on this situation, with the public planning bodies more and more willing to stand up to the medical pressure groups and shift emphasis toward the production of primary care physicians. Similarly, in the United States, the passing of "certification of need" legislation and its implementation by the health planning agencies have been accomplished in the face of strong opposition from the medical profession. Indeed, although it is inaccurate to consider the government and other organs of the state as neutral and above interest groups (a favorite assumption of the political pluralists), it is equally inaccurate to define these interest groups as the state.[43]

As pointed out before, the infrastructure for the national and regional planning system could be built from the presently available groups of policy planners, regulators, analyzers, and data collectors at the federal, state and local levels, although this would require the strengthening of some groups, the creation of others, and the development of interdependencies that would relate them functionally.

At the federal level, two groups could be established; a policy planning group at the level of the Secretary's office to assist in the analysis of political alternatives for meeting the political objectives defined by the Secretary and the political bodies, and a second planning group at the HSMHA level which would (1) in collaboration with the regional offices of H.E.W., other governmental, paragovern-

[42] P. M. Ellwood, "Models for Organizing Health Services and Implications of Legislative Proposals."

[43] For an expansion of this point, see V. Navarro, "National Health Insurance and the Strategy for Change."

mental, and private agencies, prepare the long, medium and short-term federal plans for health services, and (2) assist and stimulate the preparation and development of state and local health plans. To be effective, such a planning function would naturally require that the tasks of the federal regulators and data collectors be guided by it, as outlined in the previous pages. The functions of regulation and data collection should also be centralized in two separate divisions of the HSMHA, according to the suggestion made at the beginning of this chapter.

At the state and local levels, the health planning agencies should guide the data collection and regulating agencies. Also, strengthening a trend which appears to be developing in the United States in the 1970's, regulating agencies should be established at the state and local levels which would regulate operating as well as capital expenditures, and the nature and distribution of physical as well as human resources in the health sector. The required norms and standards should be prepared (1) by those agencies, under the guidance of the state and areawide planning agencies, (2) according to federal guidelines, (3) in collaboration with other public and private groups, (4) and be defined in the long, medium and short-term state and local plans.

Obviously, the nature of all these groups as well as their interrelationships will vary according to "need" as perceived by the political forces that influence the debate on the evolution of the legislative process. And whatever their shape, these relationships will undoubtedly provide great variety, and reflect the diversity of the United States health care scene. There will be a process of evolution, however, which will offer room and occasion demand for a tidying up the often criticized nonsystem and its resources. And it is in this process that the United States can undoubtedly benefit by learning from other countries' experiences, from their successes as well as their failures.

It is partly with this intention that this monograph has been written. Of course, the value of the Swedish experience, as of other experiences, lies not in its direct applicability to the United States or to any other country; each society has to develop its own philosophy that will generate its own system. Indeed, the great variety of responses to what can be considered identical questions adds to the wealth of human experiences. This variety and wealth, however, do not deny but strengthen the value of the underlying principles that unite human experience.

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